

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
9010 CERTIFICATE OF DEATH 09001									
1. PLACE OF DEATH a. COUNTY <b>Cecil</b>					2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE <b>Maryland</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>					c. LENGTH OF STAY IN 15 <b>18yrs. 10mo. 7days</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>					d. STREET ADDRESS <b>3017 Barclay</b>				
3. NAME OF DECEASED (Type or print) <b>ANGELO (NMI) BIANCERINI</b>					4. DATE OF DEATH Month <b>August</b> Day <b>1</b> Year <b>19 61</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-11-89</b>		9. AGE (In years last birthday) <b>72</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13. FATHER'S NAME <b>Unknown</b>					14. MOTHER'S MAIDEN NAME <b>Unknown</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes WW-I</b>					16. SOCIAL SECURITY NO. <b>Not available</b>				
17. INFORMANT <b>Hospital Records, VAH, Perry Point, Md.</b>					Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> 204.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Leukemic infiltration of kidneys</b> (c) <b>Chronic Lymphocytic leukemia</b>								INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b> <b>unknown</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>VA 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Baltimore</b>		20g. (County) <b>Balto.</b>	
20h. (State) <b>Md.</b>		21. I certify that <del>Dr. G. L. Mooney</del> attended the deceased from <b>September 25 1942</b> to <b>August 1, 1961</b> and that death occurred at <b>6:35 am</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>A. L. MOONEY</b>				M.D. <b>Asst. Clinical Pathologist, V.A. Hospital, Perry Point, Md.</b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>8-1-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. L. MOONEY</b>				22d. ADDRESS <b>Asst. Clinical Pathologist, V.A. Hospital, Perry Point, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8-3-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Natl. Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Balto. Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>John C. Miller, 2433 E. Oliver St. Baltimore, Md.</b>				ADDRESS <b>2433 E. Oliver St. Baltimore, Md.</b>		25a. REC'D BY REGISTRAR <b>AUG 7 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>	



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISM  
SM 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
9011 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
09002									
1. PLACE OF DEATH a. COUNTY <b>Cecil</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Conowingo</b>					c. LENGTH OF STAY IN 1b <b>4 hours</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					e. STREET ADDRESS <b>3903 Frankford Ave</b>				
3. NAME OF DECEASED (Type or print) <b>Clarence Robert Blackwell</b>					4. DATE OF DEATH Month <b>8</b> Day <b>15</b> Year <b>1961</b>				
5. SEX <b>M</b>		6. COLOR OR RACE <b>W.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-7-1909</b>		9. AGE (in years last birthday) <b>52</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bus driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore Transit Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Tenn</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>James Charles Blackwell</b>					14. MOTHER'S MAIDEN NAME <b>Sallie Butler</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(Yes, no, or unknown)</b>					16. SOCIAL SECURITY NO. <b>(If give war or dates of service)</b>				
17. INFORMANT <b>Clarence R. Blackwell</b>					Address <b>Baltimore, Md.</b> <b>Mrs. James C. Blackwell 3903 Frankford Ave</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> DUE TO (b) <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>R.C. Dodson</b> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>R.C. Dodson</b> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>8-15-61</b> Address (Home, city, town, or county) <b>Rising Sun, Md.</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)			
<b>BURIAL</b>		<b>8/19/61</b>		<b>Moreland Mem.</b>		<b>BALTIMORE Md.</b>			
23. FUNERAL DIRECTOR <b>L.J. Ruck</b>					24a. REC'D BY REGISTRAR <b>5305 HARFORD Rd.</b>				
24b. REGISTRAR'S SIGNATURE <b>Aug 18 '61</b>					24c. REGISTRAR'S SIGNATURE <b>Arthur P. King</b>				

(M)

Local

Continuing

11 hours

Baltimore

1203 Franklin Ave

Clarence

Robert

Blackwell

8

12

61

M

W

8-7-1909

22

Bus driver

Baltimore Transit Co. Tenn

U.S.A.

James Charles Blackwell

Salis Butler

Baltimore, Md.

Mrs. James C. Blackwell 1203 Franklin Ave

Route Coroner's Collection

H.C. Jackson

Salis Butler

8-7-1909

9012

## CERTIFICATE OF DEATH

Reg. Dist. No.

09003

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. LENGTH OF STAY IN 1b <b>3 Hrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Union Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chesapeake City</b>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>MADLYN</b> Last <b>CALLAHAN</b>		4. DATE OF DEATH Month <b>August</b> Day <b>27</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 2, 1888</b>
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR (If UNDER 24 HRS.) Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Hogate</b>		14. MOTHER'S MAIDEN NAME <b>Lillian Arrants</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Richard M. Callahan</b>		Address <b>Ches. City, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> 420 - 1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>DIABETES MELLITUS</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 5</b> , 19 <b>36</b> , to <b>August 27</b> , 19 <b>61</b> that I last saw the deceased alive on <b>Aug 27</b> , 19 <b>61</b> and that death occurred at <b>3:04 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Henry V. Davis</b>		DATE SIGNED <b>8/28/61</b>	
PHYSICIAN'S NAME (Type) <b>HENRY V. DAVIS MD</b>		ADDRESS (Street, city or town, state) <b>Chesapeake City, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8/30/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Bethel Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Near Chesapeake City, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>PIPPIN FUNERAL HOME</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 31 '61</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2102

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(11)

(12)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9013

CERTIFICATE OF DEATH

Reg. Dist. No. 09005

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Elkton</b>		c. LENGTH OF STAY IN 1b <b>18 Yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LE ROY GLENN COLE</b>		4. DATE OF DEATH <b>August 15 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 31, 1886</b>
9. AGE (In years lost birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Edward O. Cole</b>		14. MOTHER'S MAIDEN NAME <b>Ida Tennant</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>217-20-9564</b>	
17. INFORMANT <b>Mrs. Iva C. Cole</b>		Address <b>Nr. Elkton, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic hypertensive</b> DUE TO <b>cadiovascular disease</b> (c) <b>several yrs.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 min.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>August 15, 1960</b> , to <b>August 15, 1961</b> that I last saw the deceased alive on <b>August 11, 1961</b> , and that death occurred <b>9:30 a. m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>233 E. Main Streetn</b> DATE SIGNED <b>9/15/61</b>			
ACTUAL SIGNATURE <b>S. Ralph Andrews, Jr.</b> M.D.		23. FUNERAL DIRECTOR'S SIGNATURE <b>PIPPIN FUNERAL HOME</b> ADDRESS <b>Elkton, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/18/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fair View Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Thompson, Penna.</b>	
24a. REC'D BY REGISTRAR <b>AUG 17 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanks</b>	

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For every hypothesis

Atypicality is a relative  
 condition of disease

August 15, 1913

1:30a

11

11

255 E. 11th Street

Albany, N.Y.

Dr. J. H. Anderson, Jr., M.D.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a day is necessary, a day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9014

09006

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Delaware b. COUNTY Newcastle ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East (Rural)		c. LENGTH OF STAY IN 1b ---		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wilmington Rural		d. STREET ADDRESS 41X	
3. NAME OF DECEASED (Type or print) First Middle Last Virginia H Davidson				4. DATE OF DEATH Month Day Year August 25 19 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Oct. 20, 1920	
9. AGE (In years last birthday) 40		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.		12. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pvt. Secretary				10b. KIND OF BUSINESS OR INDUSTRY Oil Ref. Catalytic		11. BIRTHPLACE (State or foreign country) Denton, Maryland	
12. CITIZEN OF WHAT COUNTRY USA				13. FATHER'S NAME Const. Edward Pennington Horsey			
14. MOTHER'S MAIDEN NAME Grace May Hubbard				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)			
16. SOCIAL SECURITY NO. 222-10-5960				17. INFORMANT Paul B. Horsey, Possum Point Rd., Dinfries, Va.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Compound fracture of both legs and both arms, face and crushed chest 819X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Car ran into abutment on Route 40 and Big North East Creek on east bound lane DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None				INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year 1:50 a.m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) North East Cecil Md			
20f. (City or town) North East				20g. (County) Cecil			
20h. (State) Md				21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED Aug 25, 1961			
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
Address (Street, city, town, or county)				22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
22b. DATE THEREOF 8-28-61				22c. NAME OF CEMETERY OR CREMATORY Denton Cemetery			
22d. LOCATION (City, town, or country) Denton				22e. (State) Md.			
23. FUNERAL DIRECTOR J. Harvey Williamson ADDRESS Federalsburg, Md				24a. REC'D BY REGISTRAR AUG 28 '61			
24b. REGISTRAR'S SIGNATURE				24c. REGISTRAR'S SIGNATURE			

700 14

RECEIVED THE SECRETARY OF THE ARMY  
WASHINGTON, D. C.

310

OFFICE OF THE  
SECRETARY OF THE ARMY

(M)

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TO THE SECRETARY OF THE ARMY  
FROM THE SECRETARY OF THE ARMY  
SUBJECT: [Illegible]  
[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or official communication.]

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any day is necessary, pay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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X  
9015  
MAYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

19017

1. PLACE OF DEATH a. COUNTY <b>CECIL</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CECILTON</b>				c. LENGTH OF STAY in 1b <b>10 minutes</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>CECILTON</b>				d. STREET ADDRESS <b>MIDDLETOWN R.D., 2</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>GEORGE P DAVIS</b>				4. DATE OF DEATH Month Day Year <b>8 29 19 61</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-23-1908</b>	
9. AGE (In years last birthday) <b>53 yrs.</b>		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>			
11. BIRTHPLACE (State or foreign country) <b>Md.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Earl Davis</b>				14. MOTHER'S MAIDEN NAME <b>Lilly Pierce</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <b>Lilly Davis, Middletown R.D. 2, Del.</b>			
17. INFORMANT <b>Lilly Davis, Middletown R.D. 2, Del.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> 720.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> <del>homicide</del> <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL <b>R.C. Dodson</b> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>R.C. Dodson</b> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Rising Sun, Md.</b> DATE SIGNED <b>8-29-61</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)	
<b>Burial</b>		<b>Sept 2, 1961</b>		<b>Forest Cemetery</b>		<b>Middletown Del.</b>	
23. FUNERAL DIRECTOR <b>Edward E. Ebbert</b>				24a. REC'D BY REGISTRAR <b>SEP 5 '61</b>			
ADDRESS <b>Wilmington Del.</b>				24b. REGISTRAR'S SIGNATURE <b>Carlton E. Hume</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9016

## CERTIFICATE OF DEATH

Reg. Dist. No. 118008

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>CECIL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NORTH EAST</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>	
c. LENGTH OF STAY IN 1b <u>2 1/2 yrs</u>		d. STREET ADDRESS <u>1 LANDING LANE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PRATT NURSING HOME</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNIE MARY DEIBERT</u>		4. DATE OF DEATH Month Day Year <u>AUGUST 31 1961</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 27, 1870</u>
9. AGE (In years last birthday) yrs <u>90</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GEORGE B. DAVIS</u>		14. MOTHER'S MAIDEN NAME <u>JULIA HITCHENS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>CELLIS DEIBERT</u>		Address <u>ELKTON, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio-Vascular Failure</u> <u>572X</u> DUE TO <u>A.S.C.V.D. Decompensated</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Glomerulo Nephritis &amp; Nephrosis</u> DUE TO (c) <u>Chronic Cholecystitis &amp; Chronic Rheumatoid Arthritis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 MIN.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Cholecystitis &amp; Chronic Rheumatoid Arthritis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-5-1958</u> to <u>8-31-1961</u> , that I last saw the deceased alive on <u>8-30-1961</u> , and that death occurred at <u>8:25 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>North East Md.</u> ACTUAL SIGNATURE <u>Luis M. CUZA</u> M.D. <u>Cecil Ave.</u> PHYSICIAN'S NAME (Type) <u>Luis M. CUZA</u> M.D. <u>NORTH EAST Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>SEPT. 3, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ELKTON CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ELKTON, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>PIPPIN FUNERAL HOME</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 5 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>William S. Hume</u>			





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 9017 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69009

**1**  
**FOR STATE HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, pages 2, 3 and 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Cecil</u> <span style="float: right;"><u>MARYLAND</u></span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charlestown (Rural)</u> c. LENGTH OF STAY in 1b <u>1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ---				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <u>Pennsylvania</u> <span style="float: right;">b. COUNTY <u>Berks</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oley Township</u> d. STREET ADDRESS ---											
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Horace</u> Middle <u>D</u> Last <u>Dry</u> <b>4. DATE OF DEATH</b> Month <u>Aug.</u> Day <u>14</u> Year <u>1961</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>July 21, 1887</u>		<b>9. AGE</b> (In years last birthday) <u>74</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <u>---</u> Days <u>---</u>		<b>11. IF UNDER 24 HRS.</b> Hours <u>---</u> Min. <u>---</u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Farming</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>Hereford, Pa</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			
<b>13. FATHER'S NAME</b> <u>Hiriam Dry</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Hettie Boyer</u>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>SS 180-20-3513</u>		<b>17. INFORMANT</b> <u>Mrs Deborah DeTurck, Oley Township, Pa.</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>---</u> (c), stating the underlying cause last. DUE TO (c) <u>---</u>												<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>5 min.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>---</u>														<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) ---											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>---</u> p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) ---				<b>20f. (City or town)</b> (County) (State) ---			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
<b>ACTUAL SIGNATURE</b> <u>R.C. Dodson</u>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DATE SIGNED</b> <u>Aug. 14, 1961.</u>							
<b>EXAMINER'S NAME</b> (Type) <u>R.C. Dodson, M.D.</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>							
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>22b. DATE THEREOF</b> <u>Aug. 18, 1961</u>				<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Frieden's Cemetery</u>				<b>22d. LOCATION (City, town, or country)</b> (State) <u>Oley Township Pa</u>			
<b>23. FUNERAL DIRECTOR</b> <u>Joseph A. Grant</u>				<b>ADDRESS</b> <u>Wallace Long Funeral Home, Oley, Pa.</u>				<b>24a. REC'D BY REGISTRAR</b> <u>AUG 16 '61</u>				<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Harris</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. The funeral director should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

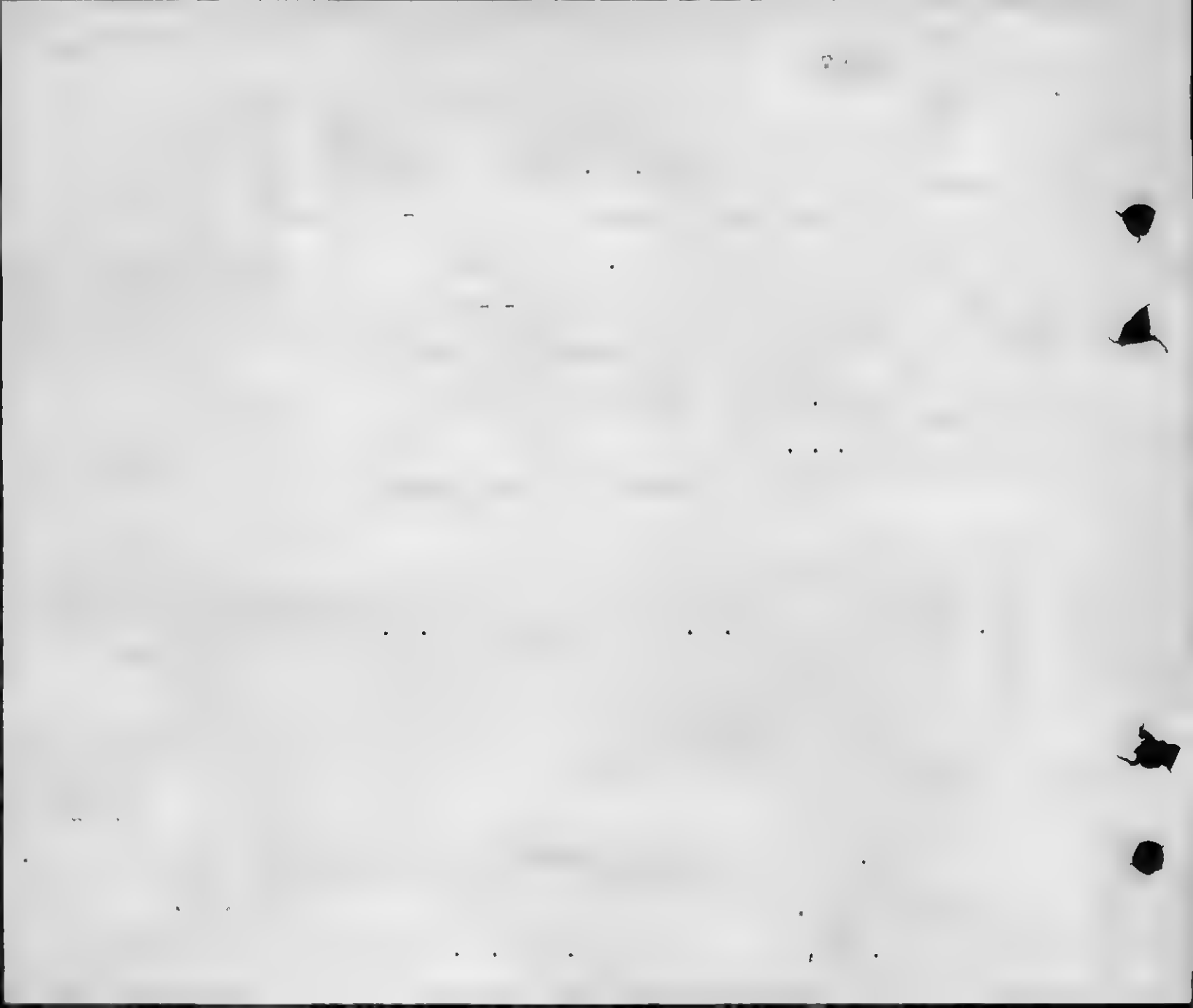
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## CERTIFICATE OF DEATH

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<b>1. PLACE OF DEATH</b> a. COUNTY Cecil		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 32yrs. 8mo. 27days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
f. STREET ADDRESS 742 - 5th Avenue		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) GEORGE A. DURST		<b>4. DATE OF DEATH</b> Month Day Year August 9 19 61	
<b>5. SEX</b> Male		<b>6. COLOR OR RACE</b> White	
<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> 3-4-74	
<b>9. AGE</b> (In years last birthday) 87 yrs.		<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>11. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Clerk		<b>12. CITIZEN OF WHAT COUNTRY?</b> USA	
<b>13. FATHER'S NAME</b> James G. Durst (deceased)		<b>14. MOTHER'S MAIDEN NAME</b> Anna Forrestelle (deceased)	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) Yes S.A.W.		<b>16. SOCIAL SECURITY NO.</b> None	
<b>17. INFORMANT</b> Hospital Records, VAH, Perry Point, Md.		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).</b> 1. Chronic Bronchitis. 2. Pulmonary Emphysema. 3. Arteriosclerosis			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, notify medical examiner) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) generalized			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. VA 19			
<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify</b> that the deceased attended the deceased from November 13 19 28 to August 9, 1961 and that death occurred at 11:10pm from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> S. Goldgraben M.D. <b>22b. DATE SIGNED</b> 8-10-61			
<b>22c. PHYSICIAN'S NAME</b> (Type) S. GOLDGRABEN, Chief, Medical Service, VA Hospital, Perry Point, Md.			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) Burial			
<b>23b. DATE THEREOF</b> Aug. 11/61			
<b>23c. NAME OF CEMETERY OR CREMATORY</b> Baltimore National			
<b>23d. LOCATION</b> (City, town or county) (State) Baltimore, Md.			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> Witzke Fun.Home, 4101 Edmondson Ave. Balto. Md.			
<b>25a. REC'D BY REGISTRAR</b> AUG 14 61			
<b>25b. REGISTRAR'S SIGNATURE</b>			

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FOR STATE  
HEALTH DEPT. (M)

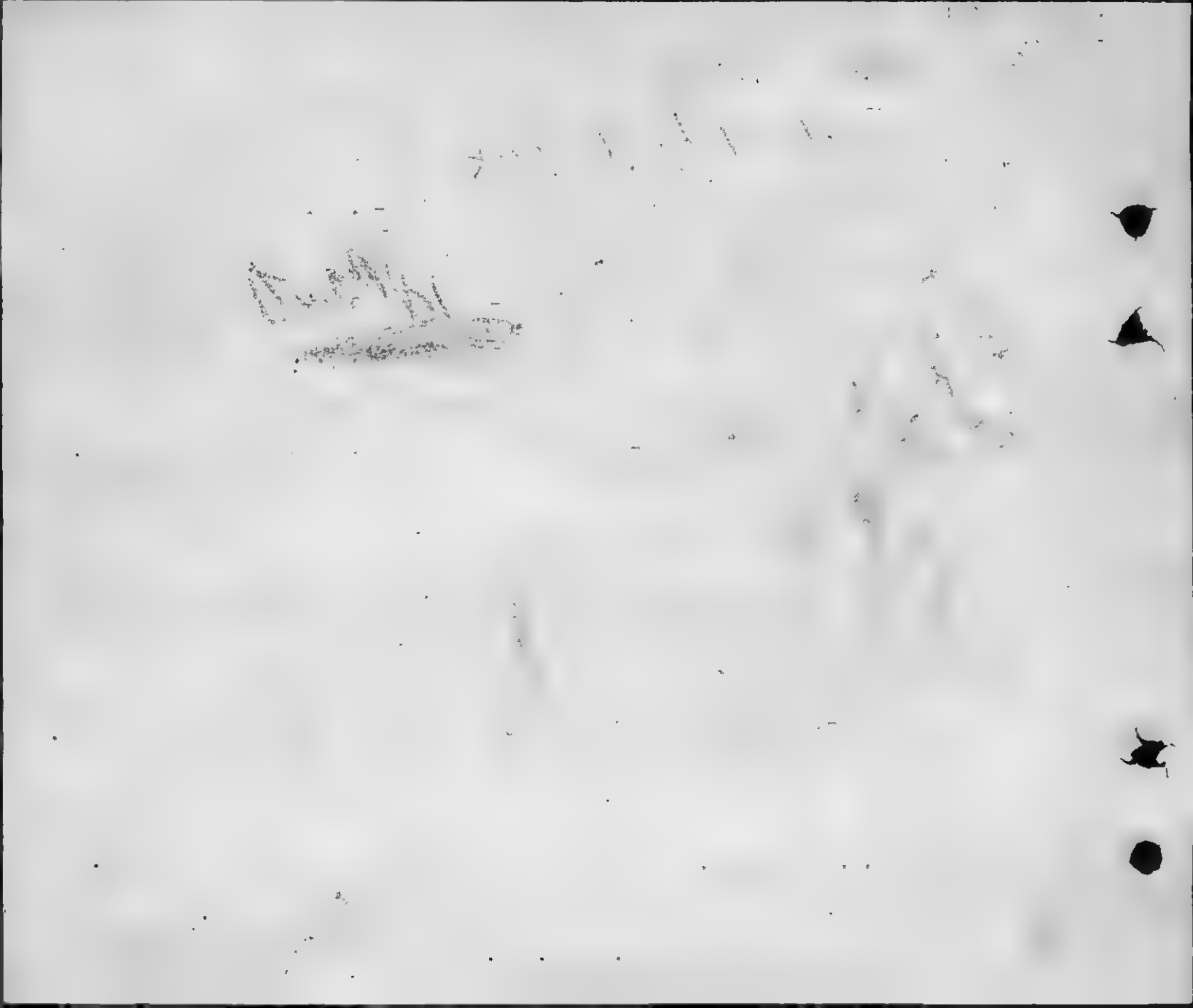
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISM  
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tem 21 Film 293 8-24-61											
MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9019 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09011											
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville				c. LENGTH OF STAY in 1b 1 yr. 25 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital						d. STREET ADDRESS 1907-W. North Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last LARRY N ENGLISH						4. DATE OF DEATH Month Day Year 8 16 1961					
5. SEX MALE		6. COLOR OR RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-22-28		9. AGE (In years last birthday) 33 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail Carrier				10b. KIND OF BUSINESS OR INDUSTRY Post Office		11. BIRTHPLACE (State or foreign country) Winston-Salem, N.C.				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Nathan Searcy						14. MOTHER'S MAIDEN NAME Lillian (?) English					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW-II				16. SOCIAL SECURITY NO. 219-28-6046		17. INFORMANT Hospital Records, VAH, Perry Point, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MANGLED BODY											
979X DUE TO STRUCK BY TRAIN											
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour XXX 6:15 p.m.		Month, Day, Year 8-16 1961		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Struck by train Perryville Cecil Md.		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>		8/16/61		DATE SIGNED	
ACTUAL SIGNATURE R.C. DODSON, M.D.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) R.C. DODSON, M.D.						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) Rising Sun, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Aug. 21, 1961		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Md.					
23. FUNERAL DIRECTOR Charles R. Law, 802 Madison Ave. Balto. Md.						24a. REC'D BY REGISTRAR DATE AUG 21 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Kneub			

MEDICAL CERTIFICATION





1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

MEDICAL CERTIFICATION

MD 9020  
MAYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Cecil		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY in 1b 1 mo. 21 days		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE New Jersey b. COUNTY		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salem		d. STREET ADDRESS 126 Thompson		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN (NMI) FAHRNER		4. DATE OF DEATH August 10 1961		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-25-95		9. AGE (in years last birthday) 65 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (State or foreign country) France		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Fahrner		14. MOTHER'S MAIDEN NAME Flora Shaw		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW-I	
16. SOCIAL SECURITY NO. unknown		17. INFORMANT Hospital Records, VAH, Perry Point, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1. Suffocation by drowning. 92958 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Less than 10 minutes		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2. Cataracts, bilateral.		21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year 8 10 19 61 Hour MIN. 7: p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Susquehanna River		20f. (City or town) Perry Point, Md.		20g. (State) Cecil	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial		22b. DATE THEREOF 8-14-61		22c. NAME OF CEMETERY OR CREMATORY Presbyterian		22d. LOCATION (City, town, or country) Salem		22e. (State) N.J.		23. FUNERAL DIRECTOR Norman S. Newkirk, 54 Oak St. Salem, N.J.	
24. REC'D BY REGISTRAR AUG 14 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Kline		24c. DATE		24d. DATE		24e. DATE		24f. DATE		24g. DATE	

ACTUAL SIGNATURE

EXAMINER'S NAME (Type) R.C. DODSON

R.C. Dodson

M.D.

CHIEF MEDICAL EXAMINER ☐

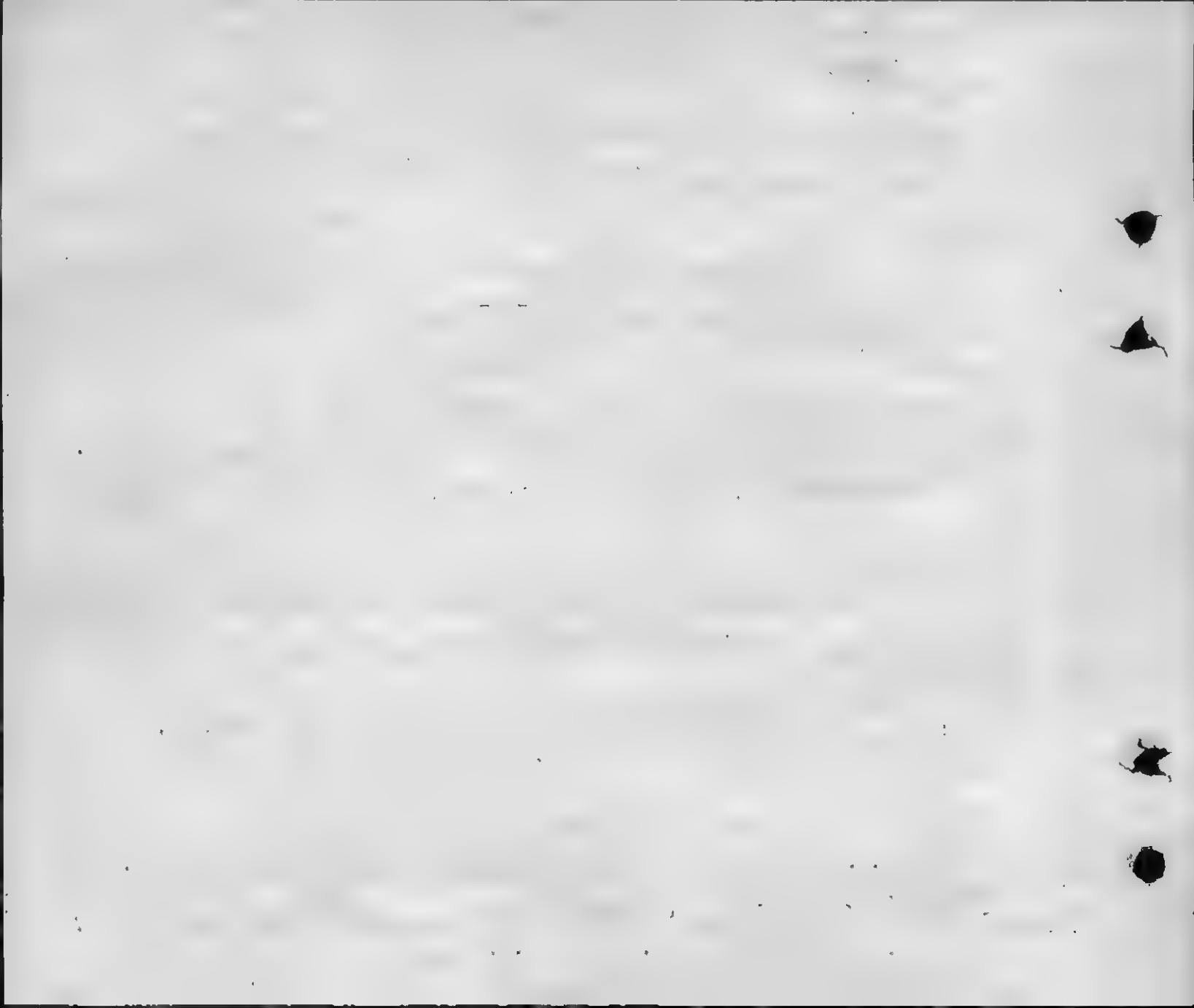
ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or country) Rising Sun, Md. (Cecil)

DATE SIGNED

8/10/61



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9021

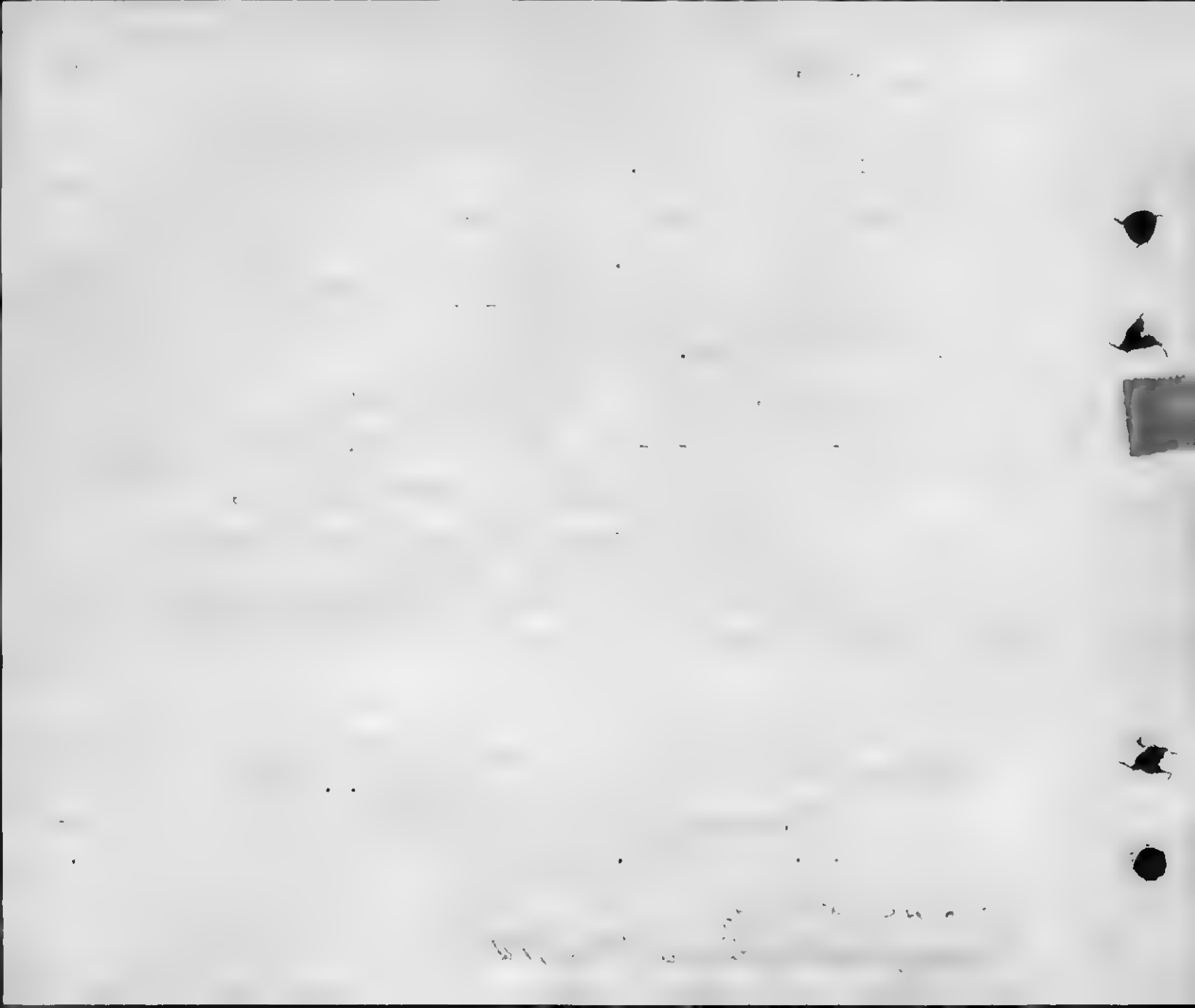
## CERTIFICATE OF DEATH

08013

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Cecil</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Point</u> c. LENGTH OF STAY IN 1b <u>2 mo. 9 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Veterans Administration Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mt. Vernon</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>12820 Holdridge Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>FLOYD</u> First <u>M.</u> Middle <u>HANNA</u> Last		<b>4. DATE OF DEATH</b> <u>August 14 1961</u>	
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>8-21-09</u>
<b>9. AGE</b> (In years last birthday) <u>51</u> yrs.		<b>10. BIRTHPLACE</b> (County & State, or foreign country) <u>Dept. of Justice Kansas</u>	
<b>11. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Accounting Clerk</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Thomas M. Hanna</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Sarah Bryant</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give word or dates of service) <u>Yes WW-II</u>		<b>16. SOCIAL SECURITY NO.</b> <u>579-12-0649</u>	
<b>17. INFORMANT</b> <u>Hospital Records, V.A.H., Perry Point, Md.</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema &amp; congestion, bilateral, severe</u> (b) <u>Adenocarcinoma of the rectum with metastasis to the liver</u> (c) <u>54X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		<b>19. INTERVAL BETWEEN ONSET AND DEATH</b> <u>2-3 days</u> <b>20. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>VA</u> 19 p.m.	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town) (County) (State)</b>
<b>21. I certify</b> that <del>(XXXXXX)</del> attended the deceased from <u>June 5, 1961 to August 14, 1961</u> and that death occurred at <u>10:35 a.m.</u> from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <u>A. L. Mooney</u> M.D.		<b>22b. DATE SIGNED</b> <u>8-15-61</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>A. L. MOONEY Asst. Clinical Pathologist, V.A.H., Perry Point, Md.</u>		<b>22d. ADDRESS</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>REMOVAL</u>	<b>23b. DATE THEREOF</b> <u>8/16/1961</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington National</u>	<b>23d. LOCATION</b> (City, town or county) (State) <u>Arlington, Virginia</u>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Benjamin J. Harn, Harn &amp; Sons, Md.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>DATE AUG 17 '61</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Harn</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9022

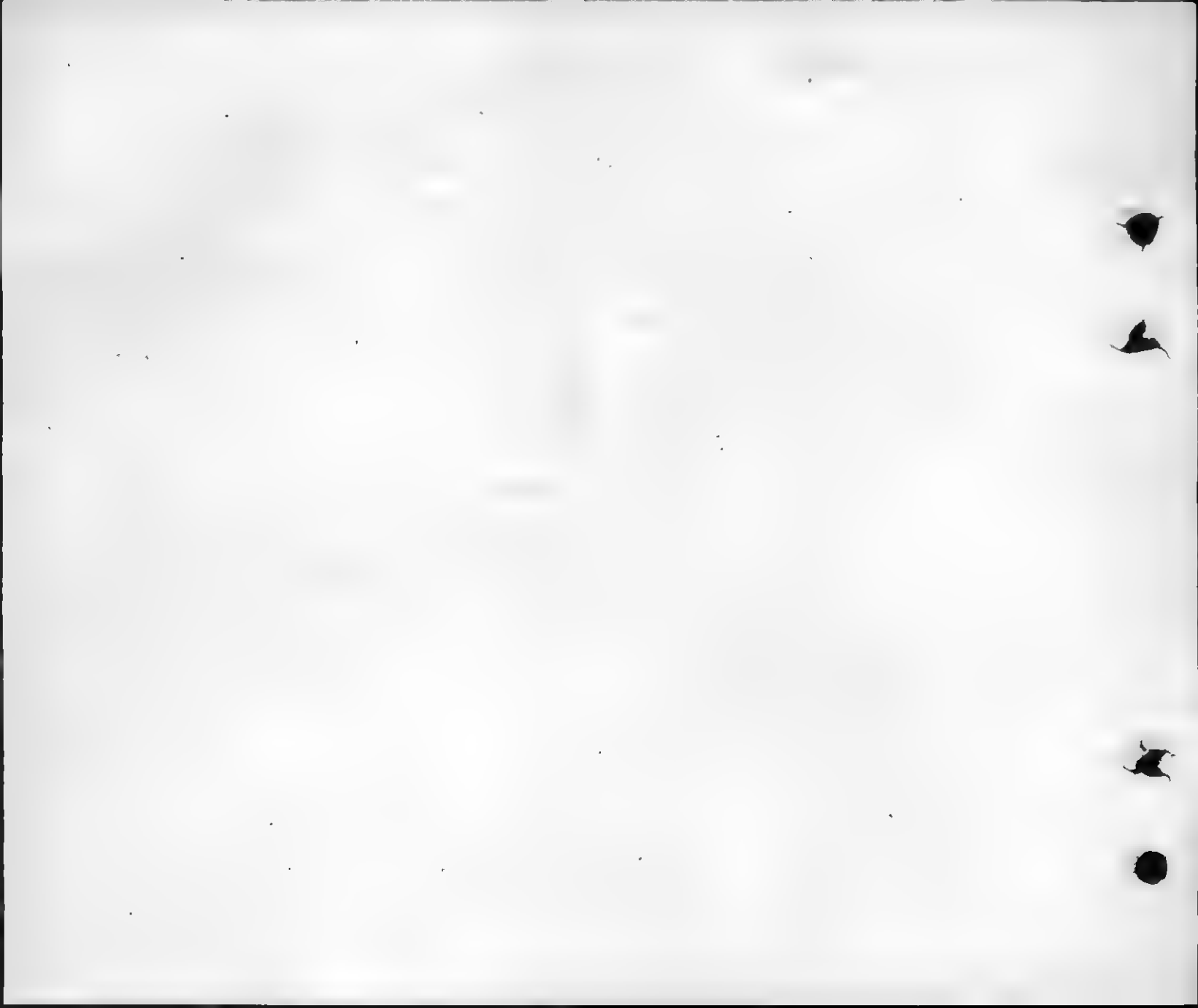
## CERTIFICATE OF DEATH

Reg. Dist. No. 08014

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. LENGTH OF STAY IN 1b <u>40 Years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital, Elkton, Maryland</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>L.</u> Last <u>Kane</u>		4. DATE OF DEATH Month <u>August</u> Day <u>24</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/27/1891</u>
9. AGE (in years last birthday) <u>69</u> yrs		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	11. IF UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Queen Anne's, Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Kane</u>		14. MOTHER'S MAIDEN NAME <u>Priscilla Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> If yes, give war or dates of service		16. SOCIAL SECURITY NO <u>212-18-2315</u>	
17. INFORMANT <u>Mrs. Geraldine Lane</u>		18. ADDRESS <u>214 East High St. Elkton, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Central Pneumonia</u> DUE TO (b) <u>Pulmonary Congestion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Acute Nephritis and Acute Gastritis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>1-Day</u> <u>1-Day</u> <u>3-Days</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>August 22, 1961</u> to <u>August 25, 1961</u> , that I last saw the deceased alive on <u>August 25, 1961</u> and that death occurred at <u>8 A:</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>245 East High Street</u> DATE SIGNED <u>8/26/61</u>			
ACTUAL SIGNATURE <u>James L. Johnson</u> M.D.		22. PHYSICIAN'S NAME (Type) <u>James L. Johnson M. D.</u> <u>Elkton, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/29/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ebenezer Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Bohemia Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John P. Bell</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 30 '61</u>	
ADDRESS <u>909 Poplar St.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Tuma</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





1  
FOR STATE  
HEALTH DEPT.

M

1. PLACE OF DEATH  
a. COUNTY

Cecil

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Elkton

c. LENGTH OF STAY IN 1b

5 hours

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Union Hospital

3. NAME OF DECEASED  
(Type or print)

First

Middle

Last

Frank

L

LEMON

Lemon

5. SEX

M

6. COLOR OR RACE

W

7. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

7-26-1876

9. AGE (in years last birthday)

85 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10b. KIND OF BUSINESS OR INDUSTRY

Laborer

11. BIRTHPLACE (State or foreign country)

Pa.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William Lemon

14. MOTHER'S MAIDEN NAME

Emma Cloud

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Mrs. Patricia Lemon, 905 E. Orange St., Lancaster, Pa.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Insulin Shock, Hypoglycemia

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a.m. p.m.

20d. INJURY OCCURRED While ☐ Not While ☐  
at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

*R.C. Dodson*

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

Rising Sun, Md.

8-20-61

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

8/23/61

22c. NAME OF CEMETERY OR CREMATORY

Cedar Lawn

22d. LOCATION (City, town, or country)

Lancaster, Penna.

(State)

23. FUNERAL DIRECTOR

*John Funeral Home*

ADDRESS

*2546 Mount N. A. Lushy Elkton, Md.*

24a. REC'D BY REGISTRAR

AUG 24 '61

24b. REGISTRAR'S SIGNATURE

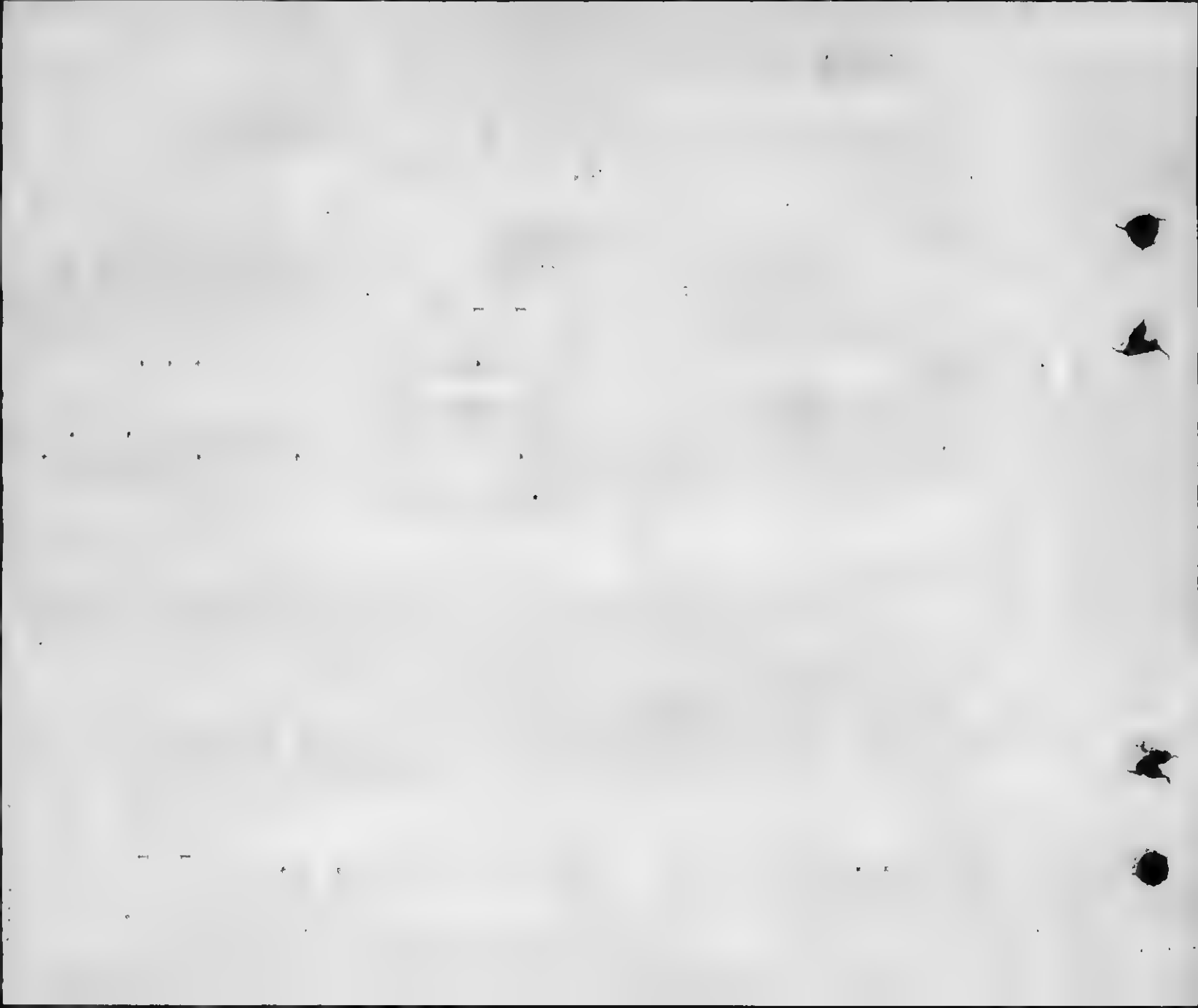
*Arthur J. Hume*

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
9023 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08015



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

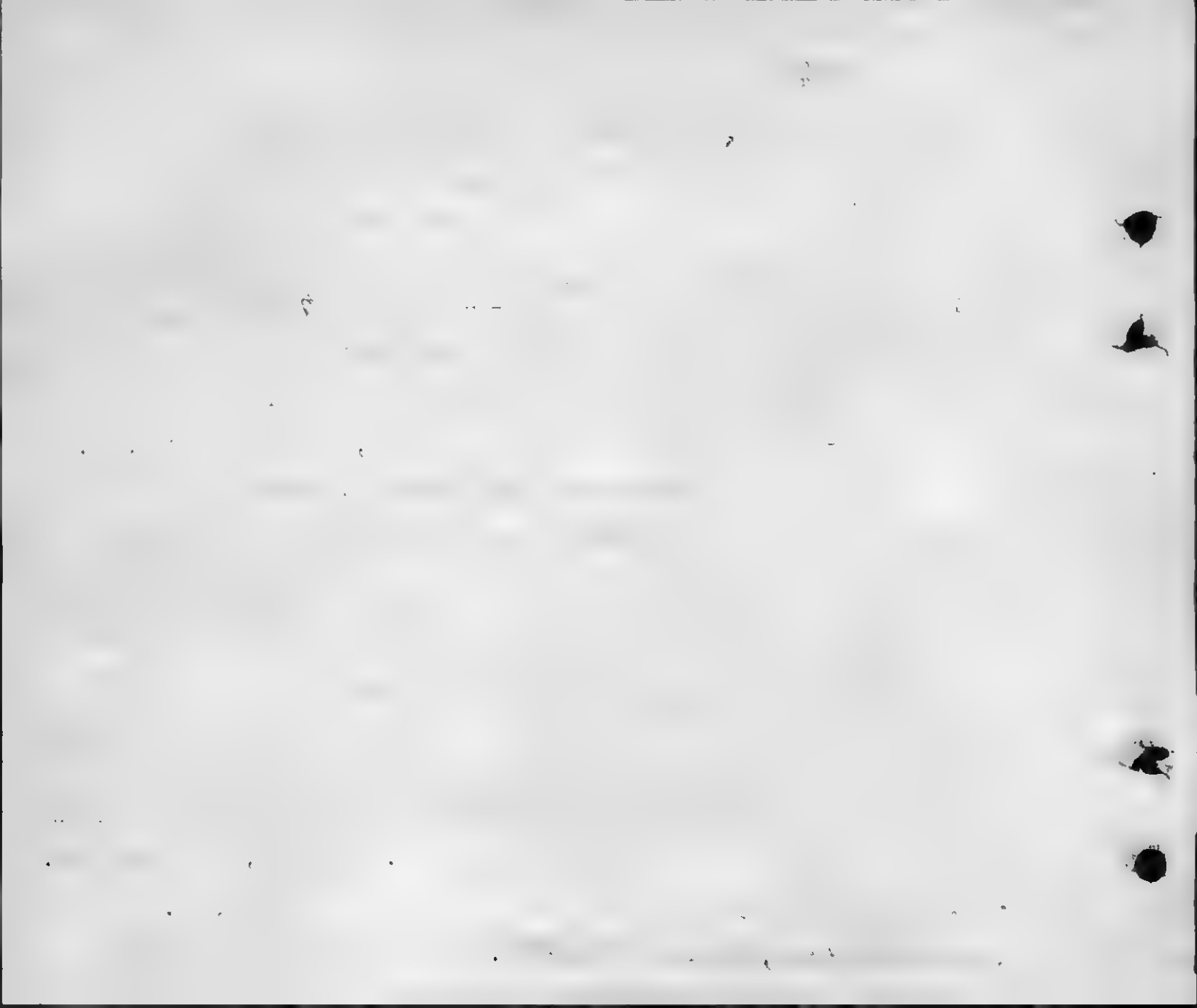
9024

08016

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Cecil</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Point</u> <span style="float: right;">36 yrs</span> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Veterans Administration Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Pennsylvania</u> <span style="float: right;">b. COUNTY <u>✓</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pittsburgh</u> d. STREET ADDRESS <u>2256 Almont</u>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>FRED</u> Middle <u>(NMI)</u> Last <u>LOEFFEL</u>		<b>4. DATE OF DEATH</b> Month <u>August</u> Day <u>18</u> Year <u>19 61</u>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>11-6-91</u>		9. AGE (in years at birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steel Corporation</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Alexander Loeffel</u>		14. MOTHER'S MAIDEN NAME <u>Rosina (?) Loeffel</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW-I</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Hospital Records, VAH, Perry Point, Md.</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Pulmonary edema and congestion, severe</u> (b) <u>Arteriosclerotic heart disease</u> (c) <u>unknown</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH <u>3-4 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <u>Arteriosclerosis generalized severe</u>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>VA</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that <u>Dr. J. L. Garey</u> attended the deceased from <u>August 29, 1955, to August 18, 1961</u> and that death occurred at <u>3:15 am</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>J. L. Garey</u>		M.D. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>8-18-61</u>			
22c. PHYSICIAN'S NAME (Type) <u>J. L. GAREY</u>		22d. ADDRESS <u>Clinical Pathologist, V.A. Hospital, Perry Point, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE THEREOF <u>8/19/1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Zimmerman</u>			
23d. LOCATION (City, town or county) <u>Pittsburgh, Pa.</u>		23e. (State)					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kraus</u>		ADDRESS <u>Birmingham, Ala., Harvade Ave., Md.</u>		25a. RECD BY REGISTRAR <u>AUG 22 61</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		DATE					

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

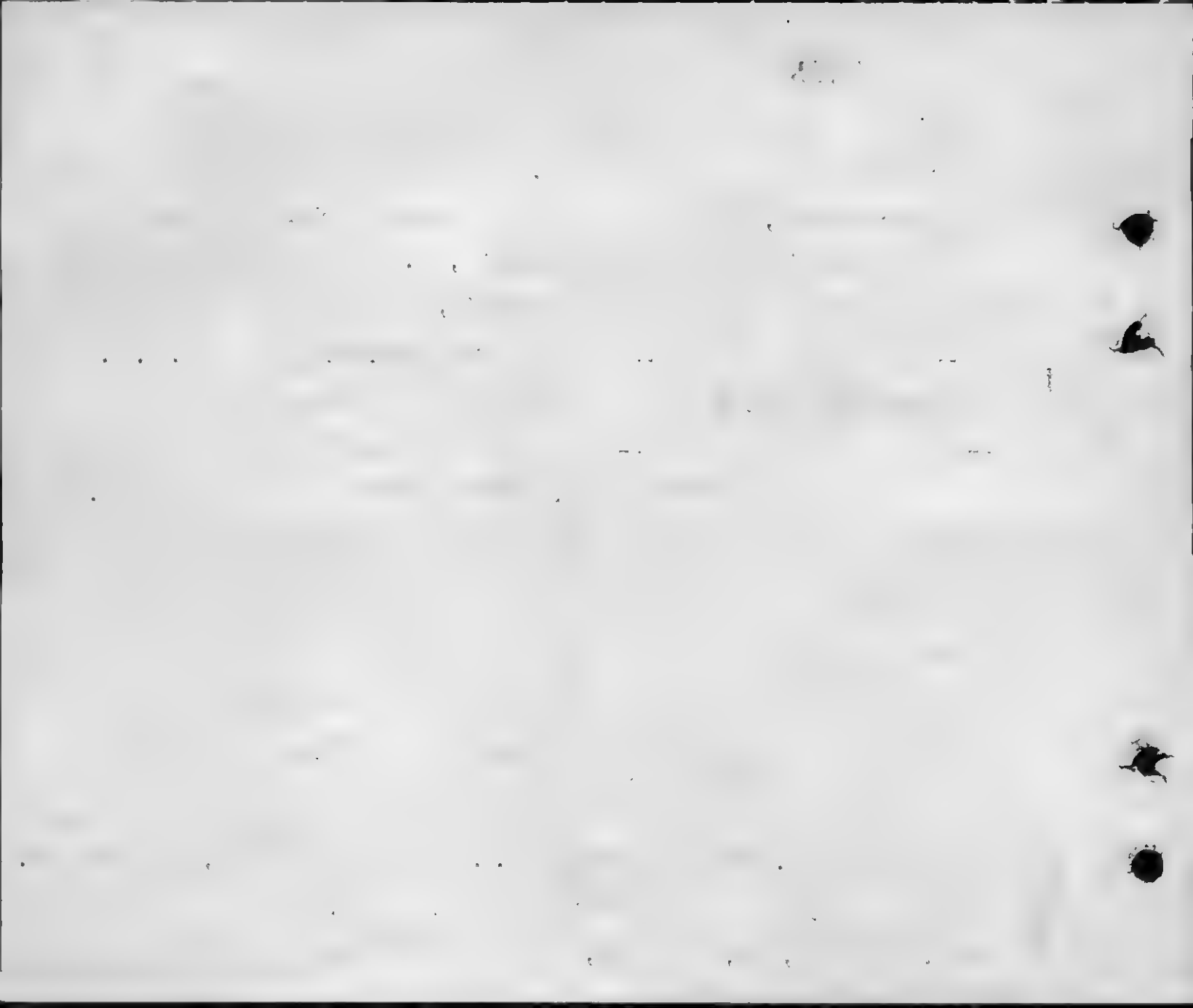


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9025 CERTIFICATE OF DEATH 09017											
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Cecil						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bainbridge					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit						
c. LENGTH OF STAY IN b. 1 day 8 1/2 hrs.					d. STREET ADDRESS 234-Al Laffey Circle, Manor Heights						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Station Hospital, USNTC					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Richard Frank Manteufel, Jr.					4. DATE OF DEATH August 22 1961						
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 21, 1961		9. AGE (In years last birthday) yrs. 1			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTH-PLACE (County & State, or foreign country) Cecil County, Maryland	
13. FATHER'S NAME Richard Frank Manteufel					14. MOTHER'S MAIDEN NAME Masako (n) Soejima					12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO. 17. INFORMANT Hospital Records					Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 776X PREMATURE BIRTH, NEONATAL DEATH Conditions, if any, which gave rise to immediate cause (b) DUE TO (a), stating the underlying cause last. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH 32 hr. 30 min	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from August 21 1961 to August 22, 1961, that (I) (we) last saw the deceased alive on August 22, 1961, and that death occurred at 5:00 PM, from the causes and on the date stated above.			
22a. SIGNATURE Gordon B. Avery M.D.					22b. DATE SIGNED 8-23-61		22c. PHYSICIAN'S NAME (Type) GORDON B. AVERY LT MC USN				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 8-24-61		23c. NAME OF CEMETERY OR CREMATORY West Nottingham Cemetery		23d. LOCATION (City, town or county) (State) Colorado Maryland		
24. FUNERAL DIRECTOR'S SIGNATURE LEE A. PATTERSON & SON					ADDRESS Perryville, Maryland		25a. REC'D BY REGISTRAR DATE 8/23/61		25b. REGISTRAR'S SIGNATURE		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

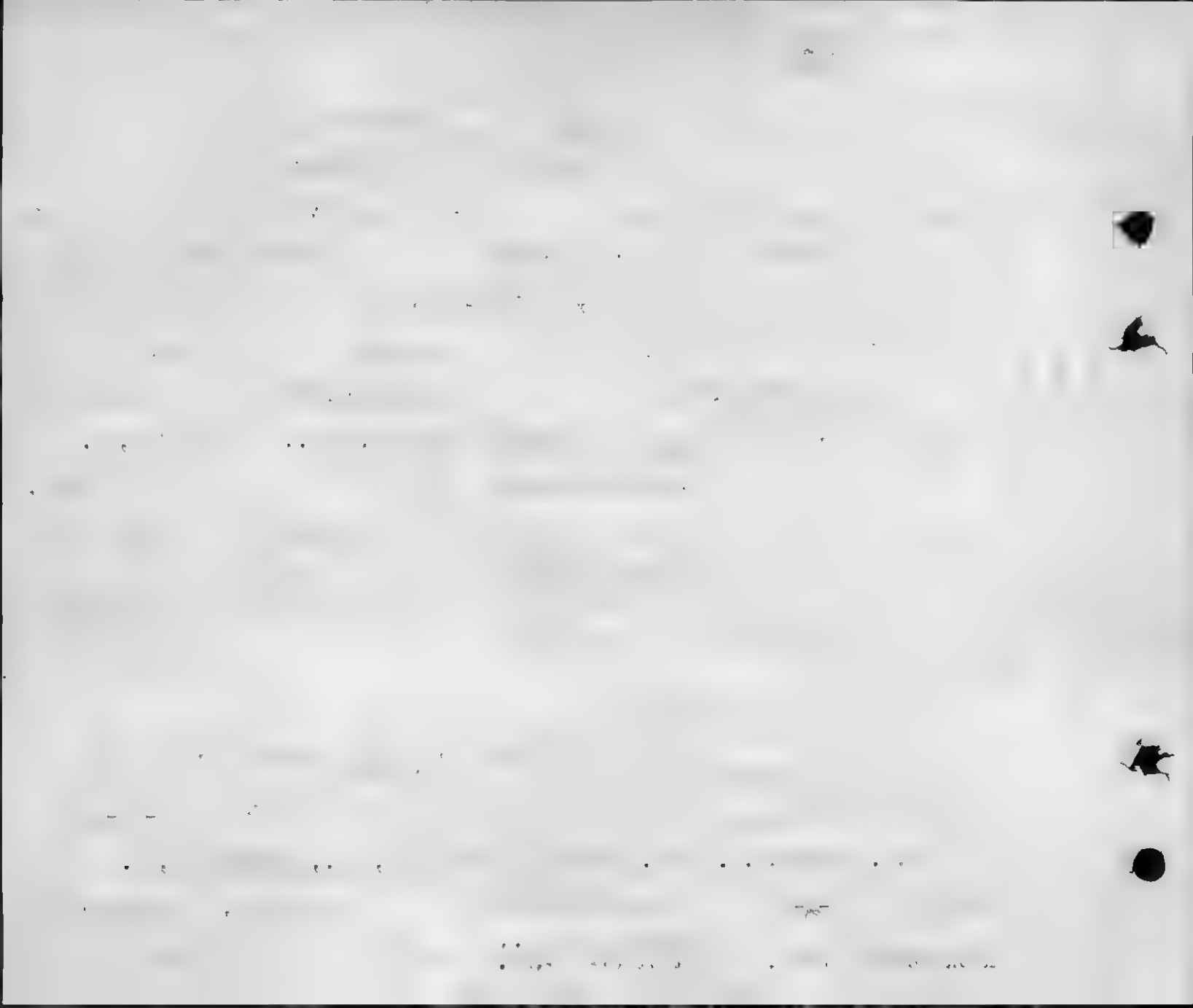
VR A15 (4)  
15M 9/60

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

9026

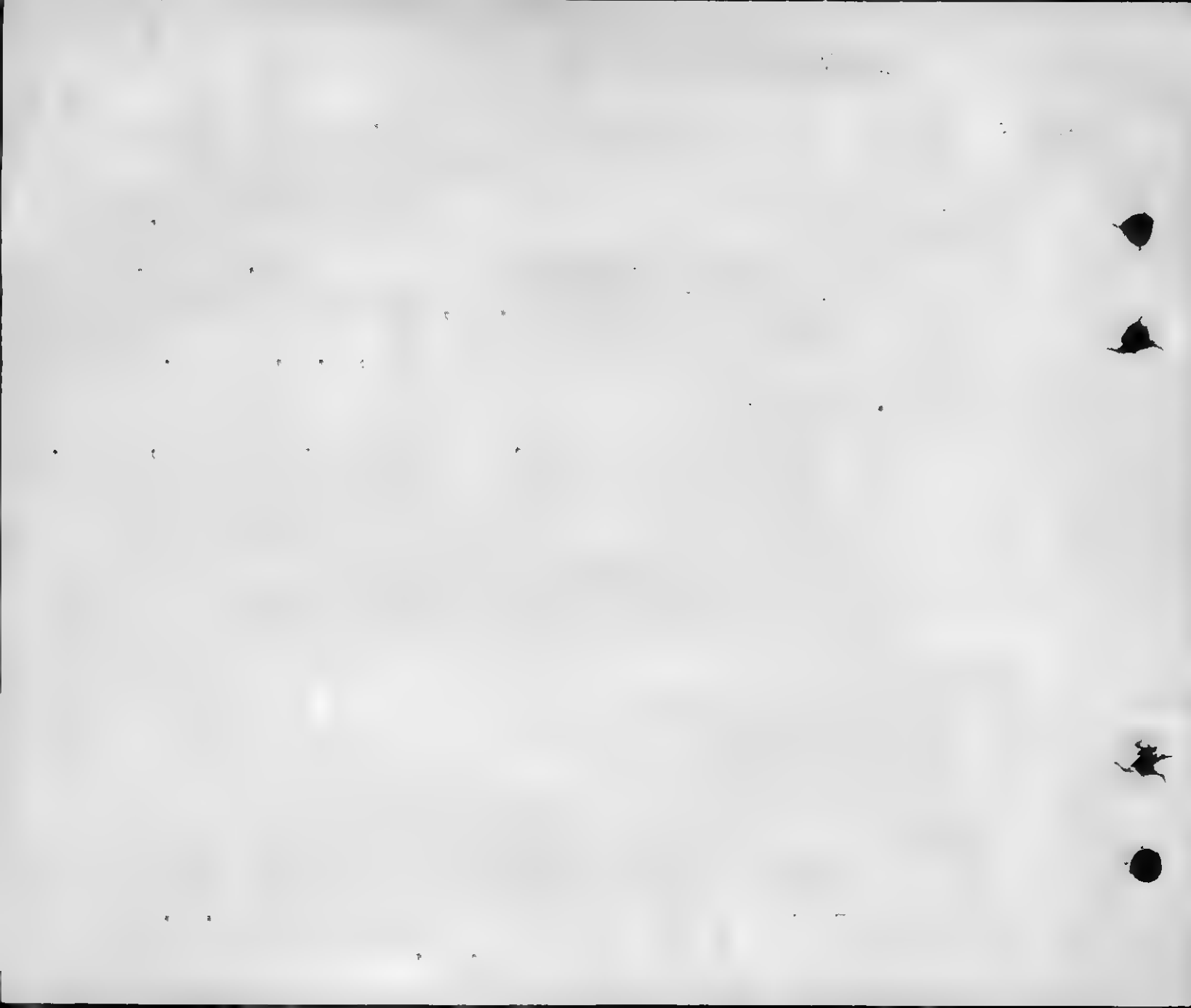
09018

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Cecil</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b> c. LENGTH OF STAY IN 1b <b>25yrs 26days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>9648 Alda Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>ALBERT L. MAPUS</b>		<b>4. DATE OF DEATH</b> Month <b>August</b> Day <b>30</b> Year <b>1961</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input checked="" type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>October 20, 1900</b> <b>9. AGE</b> (In years last birthday) <b>60</b> yrs.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Baker</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Bakery</b>	<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Maryland</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>
<b>13. FATHER'S NAME</b> <b>JOHN HENRY MAPUS</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>ISABELLE CREAMER</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give service) <b>Yes WW-1</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b> <b>17. INFORMANT</b> <b>Hospital Records, VAH., Perry Point, Md.</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rupture of Heart</b> DUE TO <b>Due to Acute Myocardial infarction</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO <b>Coronary thrombosis</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>2 to 5 Min.</b> <b>4 to 6 days</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>Arteriosclerosis Generalized</b>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18) <input type="checkbox"/>	
<b>20c. TIME OF INJURY</b> Month. Day. Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that</b> (1) (this hospital) attended the deceased from <b>August 4, 1961</b> to <b>August 30, 1961</b> that (we) last saw the deceased alive on <b>August 30, 1961</b> , and that death occurred at <b>2:35PM</b> from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <b>A.L. Mooney</b>		<b>22b. DATE SIGNED</b> <b>8-31-61</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>A.L. MOONEY, M.D., Asst. Clinical Pathologist, VAH., Perry Point, Md.</b>		<b>22d. ADDRESS</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>9-2-61</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Baltimore National</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Baltimore, Maryland</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>RUCK FUNERAL HOME,</b>		<b>25a. REC'D BY REGISTRAR</b> <b>SEP 5 '61</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Hanna</b>	









# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 5, 6, & 7 Film G293 8/18/61 mh

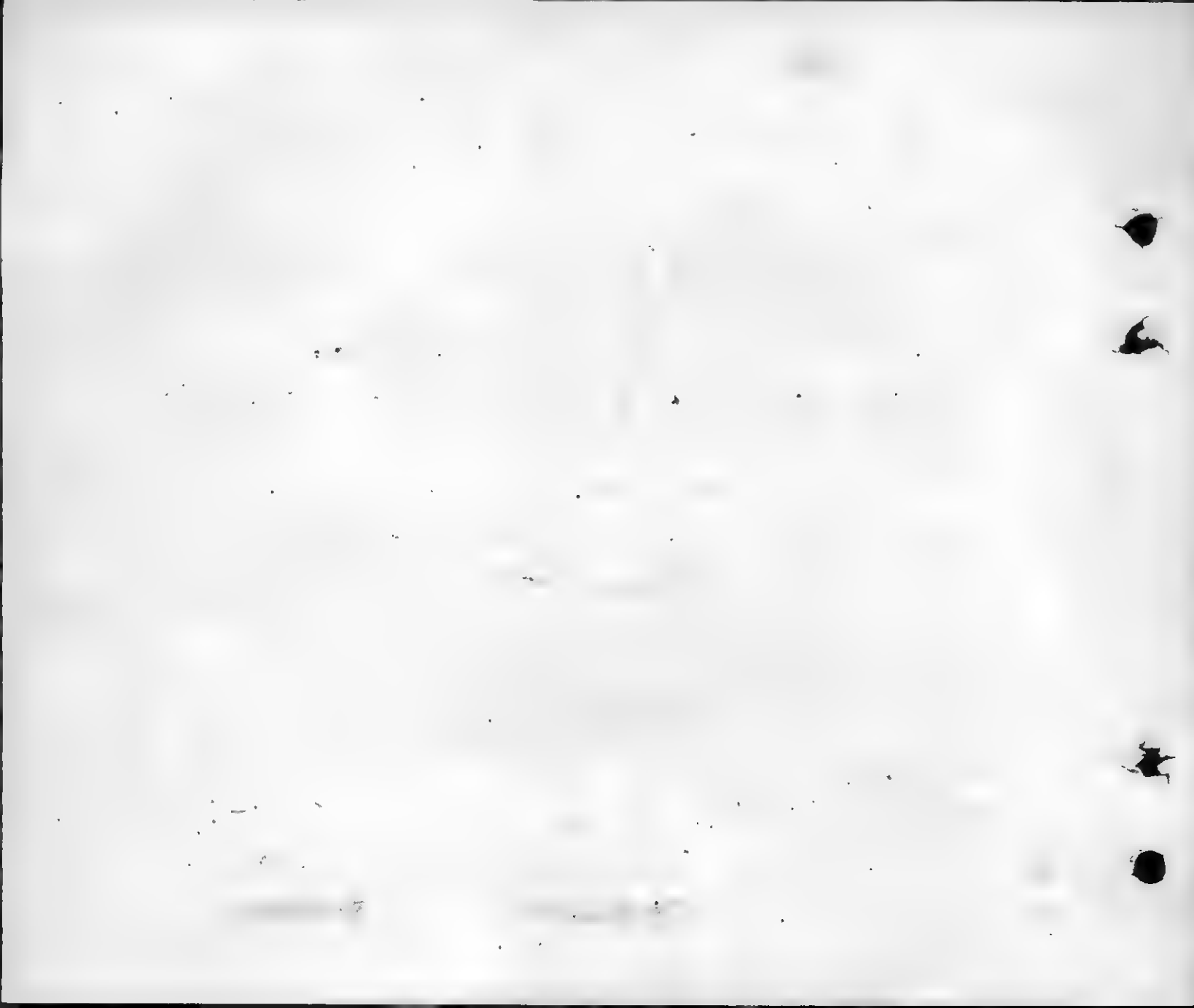
9028

## CERTIFICATE OF DEATH

Reg. Dist. No. 09020

1. PLACE OF DEATH a. COUNTY <b>CECIL</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>PA.</b> b. COUNTY <b>CHESTER</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ELKTON</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTCHESTER</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>UNION HOSPITAL</b>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <b>ORVILLE GRACE McCASLIN</b>				4. DATE OF DEATH Month Day Year <b>AUGUST 10 1961</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 9, 1893</b>	9. AGE (In years last birthday) <b>68</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE-WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ISSAFAHAR McCLAIN</b>				14. MOTHER'S MAIDEN NAME <b>SARA PEOPLES</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>		INFORMANT Address <b>Mrs. Joseph Orr, Rising Sun, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) <b>coronary thrombosis</b> DUE TO (c) <b>atherosclerosis, GAS</b>						INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b> <b>unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9 Aug 1961</b> to <b>10 Aug 1961</b> that I last saw the deceased alive on <b>10 Aug 1961</b> , and that death occurred at <b>11 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE TYPED <b>P.O. Box 446 Rising Sun, Md. 10 Aug 61</b>							
ACTUAL SIGNATURE <b>Robert W. Ireland</b> M.D.				PHYSICIAN'S NAME (Type) <b>Robert W. Ireland MD Rising Sun, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/13/1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>West Nottingham</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ralph McReed</b>				24a. REC'D BY REGISTRAR DATE <b>AUG 14 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thane</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



U.S. AIRMAIL  
5M 9/60

**DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours of death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File/paged and 2 with the State Board of Health, its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

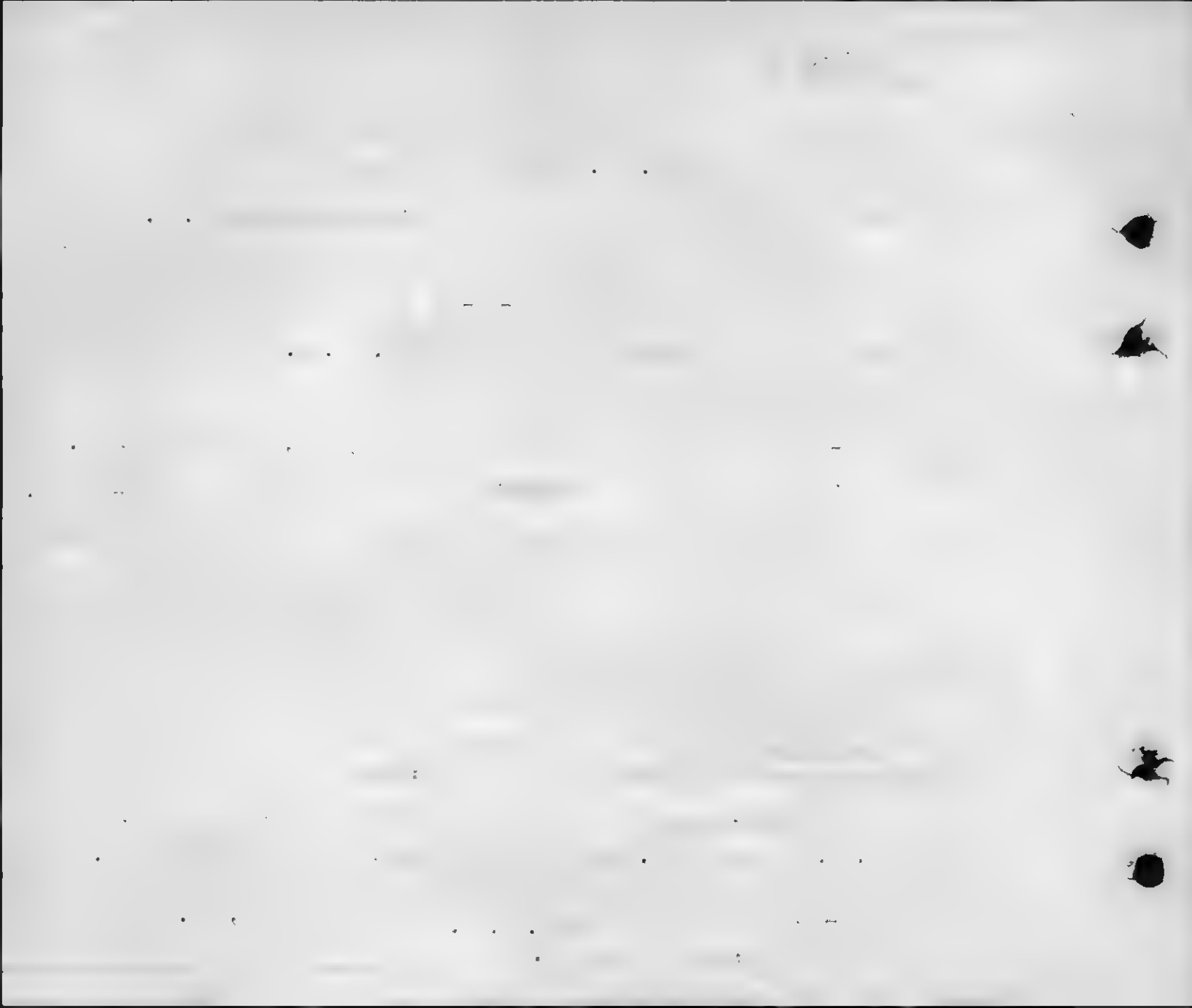


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
9030  
CERTIFICATE OF DEATH  
09022

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN 1b 34yrs.8mo.20days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND b. COUNTY District of Columbia c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 2813 Bellevue Terrace, N. W. e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FRANK (NMI) PACH First Middle Last		4. DATE OF DEATH August 7 19 61 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-22-89 Last First Middle
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Bakery	9. AGE (In years last birthday) 72 11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.
13. FATHER'S NAME William Poch		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW-I		16. SOCIAL SECURITY NO. unknown 17. INFORMANT Hospital Records, VAH, Perry Point, Md. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Arrhythmia DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic heart disease (c) Arteriosclerotic heart disease DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis generalized severe		INTERVAL BETWEEN ONSET AND DEATH 10-15 min. unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>XXXXXXXXXXXX</del> attended the deceased from November 18 1926, to August 7 1961, and that death occurred at 6:30am from the causes and on the date stated above.			
22a. SIGNATURE A. L. MOONEY 22c. PHYSICIAN'S NAME (Type) A. L. MOONEY		22b. DATE SIGNED 8-7-61 22d. ADDRESS Asst. Clinical Pathologist, VAH, Perry Point, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-9-1961	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) Arlington, Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawlers Sons, 1756 Penna Ave. NW		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9031											
CERTIFICATE OF DEATH											
09023											
1. PLACE OF DEATH a. COUNTY Cecil				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Delaware				b. COUNTY New Castle			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b 4 months				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newark			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Devine Nursing Home				d. STREET ADDRESS 78 Kells Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Lola Ellis Phillips				4. DATE OF DEATH 8-22-61				5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX Female				6. COLOR OR RACE White				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH Nov. 10, 1879				9. AGE (In years last birthday) 81 yrs.				10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Delaware			
12. CITIZEN OF WHAT COUNTRY U.S.A.				13. FATHER'S NAME Samuel Ellis				14. MOTHER'S MAIDEN NAME Ann Virginia Phillips			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. None				17. INFORMANT Claude E. Phillips			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 351X DUE TO Conditions (any, which gave rise to immediate cause (a), stating the underlying cause last, (b) arteriosclerosis, cerebral DUE TO Generalized arteriosclerosis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH 5 days 4 yrs 5 yrs							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) Newark				20g. (County) Delmar				20h. (State) Delaware			
21. I certify that (I) (this hospital) attended the deceased from Mar 10, 1959, to Aug 22, 1961, that (I) (we) last saw the deceased alive on Aug 22, 1961, and that death occurred at 12:00 PM from the causes and on the date stated above.											
22a. SIGNATURE Wallace M. Johnson				22b. DATE SIGNED 8-22-61				22c. PHYSICIAN'S NAME (Type) Wallace M. Johnson			
22d. ADDRESS 257 E Main St Newark Del				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22f. DATE SIGNED 8-22-61			
23a. BURIAL, CREMATION, 23b. DATE THEREOF Burial 8-25-61				23c. NAME OF CEMETERY OR CREMATORY Ralph's Hill Cemetery				23d. LOCATION (City, town or county) Delmar, Delaware			
24. FUNERAL DIRECTOR'S SIGNATURE William J. Warwick				24a. ADDRESS Newark, Dela.				24b. REC'D BY REGISTRAR AUG 28 '61			
24c. REGISTRAR'S SIGNATURE Charles E. Frank				24d. DATE AUG 28 '61				24e. REGISTRAR'S SIGNATURE Charles E. Frank			



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

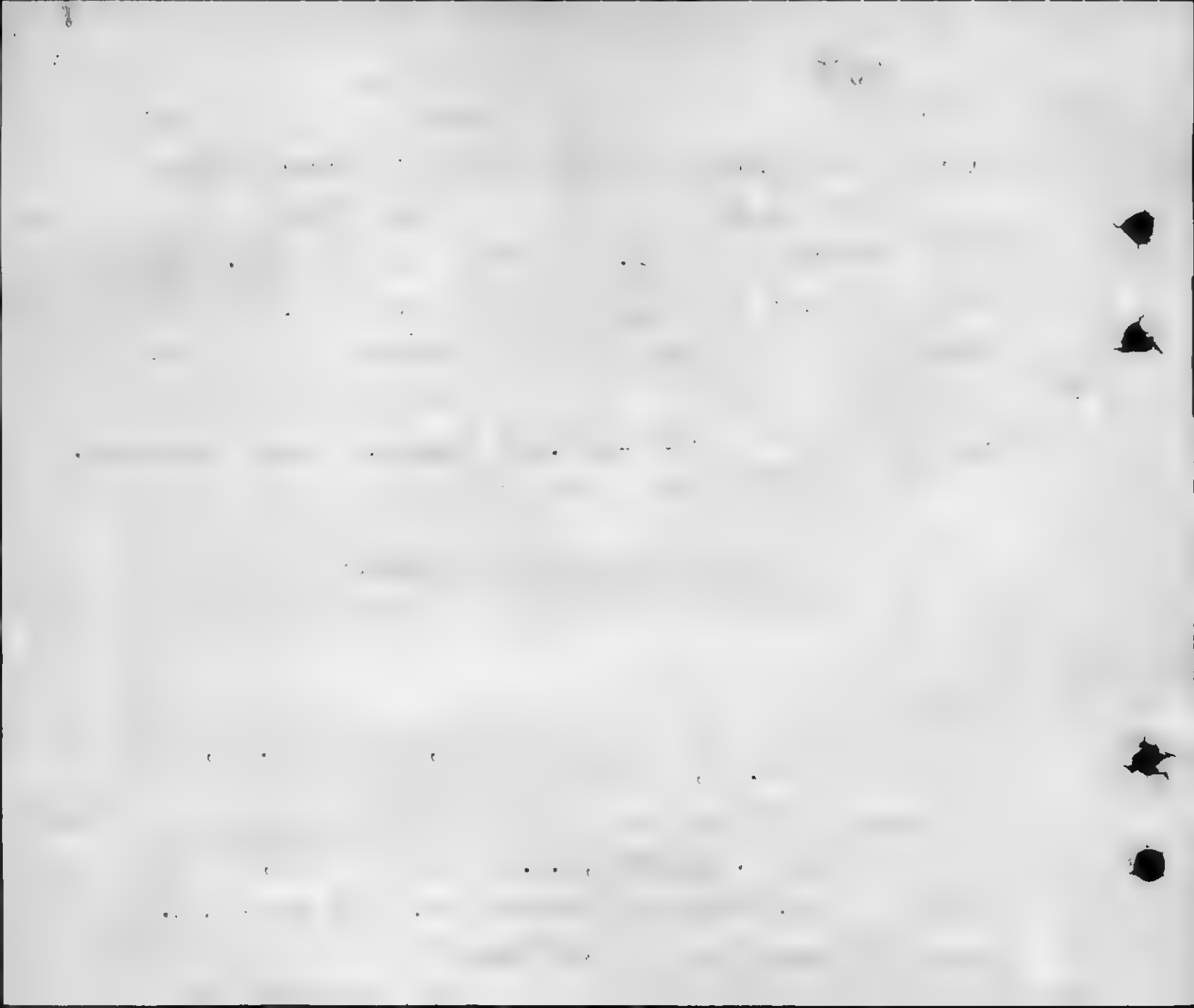
## CERTIFICATE OF DEATH

9032

09024

1. PLACE OF DEATH a. COUNTY <b>Cecil</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Principio Furnace, Rural</b>		c. LENGTH OF STAY IN b. <b>14 Yrs</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Station Lane</b>		e. STREET ADDRESS <b>Station Lane</b>	
3. NAME OF DECEASED (Type or print) <b>Francis H. Smith</b>		4. DATE OF DEATH Month <b>Aug.</b> Day <b>29</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 5, 1900</b>
9. AGE (In years last birthday) <b>61</b> yrs.		10. IF UNDER 1 YEAR Months <b>61</b> Days <b>61</b> Hours <b>61</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME <b>Unknown</b>	
14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>217-03-3111</b>		17. INFORMANT <b>Jane Hammond, Principio Furnace, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Arteriosclerotic Heart Disease</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>INTERVAL BETWEEN ONSET AND DEATH</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 11, 1961</b> to <b>Aug. 29, 1961</b> , that (I) (we) last saw the deceased alive on <b>Aug. 29, 1961</b> , and that death occurred at <b>61</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>George T. Stansbury</b>		22b. DATE SIGNED <b>8/30/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>George T. Stansbury, M.D.</b>		22d. ADDRESS <b>569 Revolution Street Havre de Grace, Maryland</b>	
23a. BURIAL CREMATION, REINTERMENT (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Sept. 1, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Jones Memorial Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Port Deposit, Md. Rural</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Lee A. Patterson &amp; Son</b>		25a. REC'D BY REGISTRAR <b>Perryville, Md</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		DATE <b>SEP 1 '61</b>	

TO HO...  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and within 72 hours after death.



9033

## CERTIFICATE OF DEATH

Reg. Dist. No. 19025

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ralph</u> Middle <u>J.</u> Last <u>Speakman, Sr.</u>				4. DATE OF DEATH Month <u>August</u> Day <u>17</u> Year <u>19 61</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 9, 1395</u>	9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months <u>66</u> Days <u>66</u> Hours <u>66</u> Min. <u>66</u>	IF UNDER 24 HRS. Months <u>66</u> Days <u>66</u> Hours <u>66</u> Min. <u>66</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Thiokol Corp.</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joshua Speakman</u>				14. MOTHER'S MAIDEN NAME <u>Carrie Shade</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>1</u>		INFORMANT Address <u>R.D. 3</u> <u>Mrs. Anna Chidester Speakman, Elkton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebro-vascular hemorrhage</u> <u>13X</u> DUE TO <u>Hypertensive cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>unknown</u> DUE TO (c) <u>unknown</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <u>Aug. 14 61</u> <u>Aug. 17 61</u>	
21. I certify that I attended the deceased from <u>Aug. 14 61</u> to <u>Aug. 17 61</u> , that I last saw the deceased alive on <u>August 16 61</u> , and that death occurred at <u>2:45a</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ralph E. Andrews, Jr.</u>		M.D. <u>S. RALPH ANDREWS, JR., M.D.</u>		ADDRESS (Street, city or town, state) <u>233 E. Main Street Elkton Maryland</u>		DATE SIGNED <u>8/17/61</u>	
PHYSICIAN'S NAME (Type) <u>S. RALPH ANDREWS, JR., M.D.</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/19/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Union, Maryland</u>		24a. REC'D BY REGISTRAR <u>Ralph E. Hicks</u>		24b. REGISTRAR'S SIGNATURE <u>Elkton, Md.</u>		DATE <u>AUG 25 '61</u>	

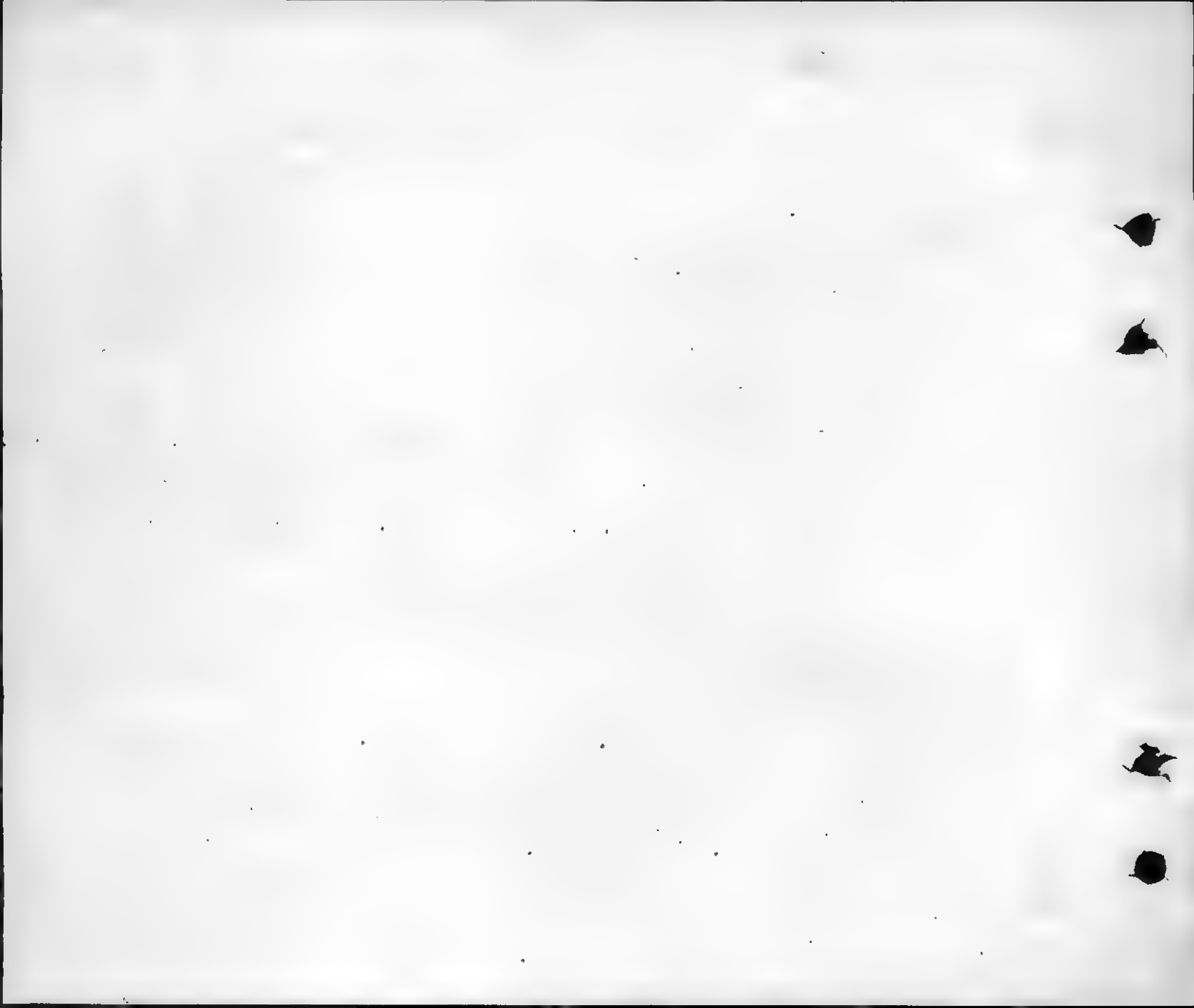
1

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. The law requires that the death certificate be completed within 24 hours after death. The law requires that the death certificate be completed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)  
15M 9/58



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

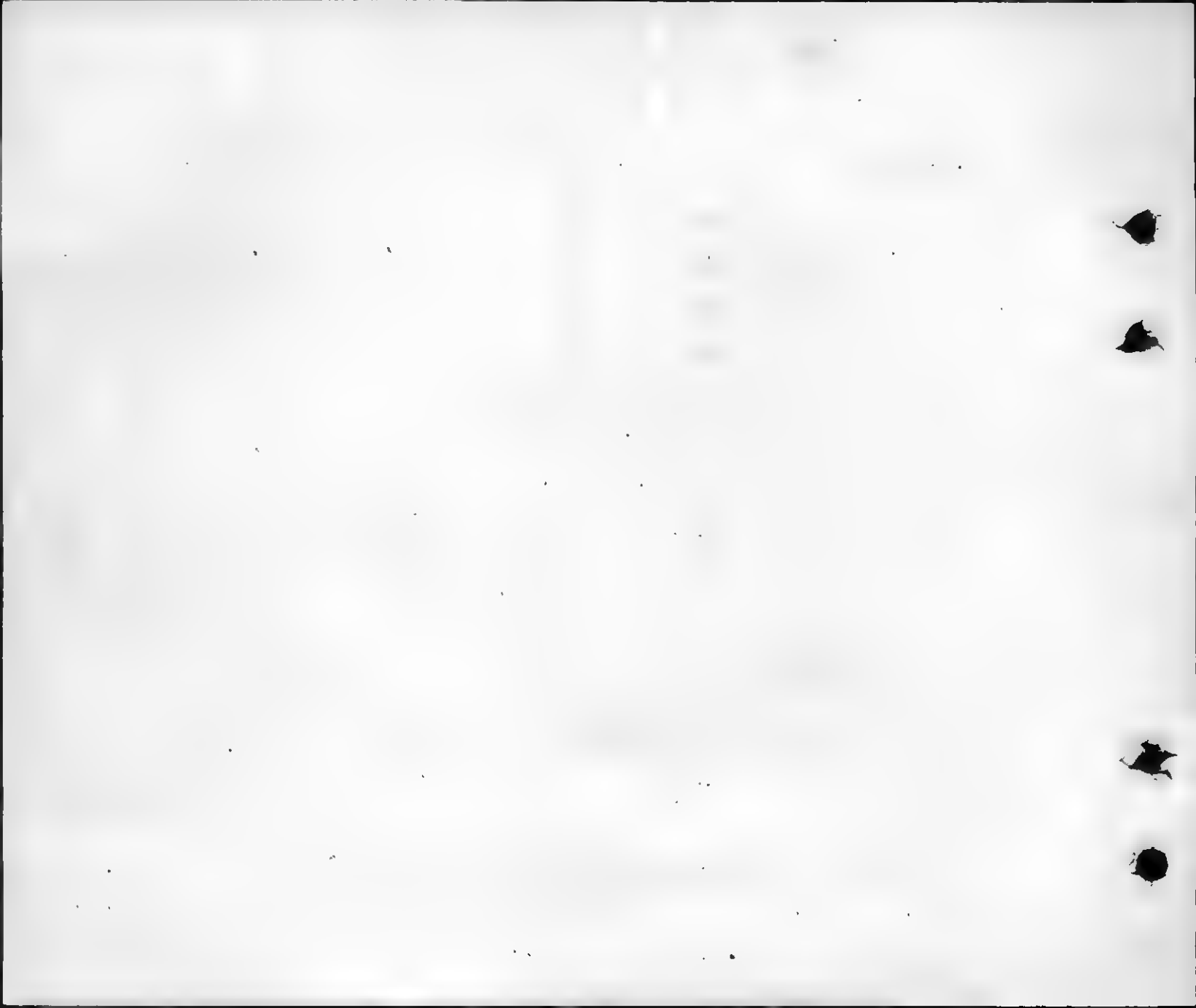
9034

## CERTIFICATE OF DEATH

Reg. Dist. No. **09026**

<b>1 PLACE OF DEATH</b> a. COUNTY <b>CECIL</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHESAPEAKE CITY</b> c. LENGTH OF STAY IN 1b <b>45 YRS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				<b>2 USUAL RESIDENCE</b> (Where deceased lived If institution. Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>CECIL</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHESAPEAKE CITY</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3 NAME OF DECEASED</b> (Type or print) <b>MARIA PASLAWSKI STATKAVICE</b>				<b>4 DATE OF DEATH</b> Month <b>AUGUST</b> Day <b>3</b> Year <b>1961</b>											
<b>5. SEX</b> <b>FEMALE</b>		<b>6. COLOR OR RACE</b> <b>WHITE</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>SEPT. 21, 1882</b>		<b>9. AGE</b> (In years last birthday) <b>78</b> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min		<b>IF UNDER 24 HRS</b> Months Days Hours Min			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>AT HOME</b>		<b>11 BIRTHPLACE</b> (State or foreign country) <b>UKRAINE</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>					
<b>13. FATHER'S NAME</b> <b>NO INFO</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>NO INFO</b>									
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <b>NONE</b>		<b>INFORMANT</b> <b>MRS. ESTELLE LUZETSKY</b>				Address <b>CHESAPEAKE CITY MD</b>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] <b>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)</b> <b>151X DUE TO</b> <b>acute leukemia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>DUE TO</b> <b>Carcinoma of Stomach</b> <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>												<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>3 days</b> <b>6 months</b>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)							
<b>21. I certify that I attended the deceased from</b> <b>Aug 10, 1931</b> <b>to Aug 3, 1961</b> <b>that I last saw the deceased alive on Aug 3, 1961</b> <b>and that death occurred at 10:40 AM</b> <b>from the causes and on the date stated above.</b> <b>ADDRESS (Street, city or town, state)</b> <b>CHESAPEAKE CITY MD</b>															
<b>ACTUAL SIGNATURE</b> <b>Henry V. Davis</b> <b>M.D.</b>												<b>DATE SIGNED</b> <b>8/8/61</b>			
<b>PHYSICIAN'S NAME (Type)</b> <b>HENRY V. DAVIS MD</b> <b>CHESAPEAKE CITY</b>															
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>				<b>22b. DATE THEREOF</b> <b>8/5/61</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>ST. ROSES</b>				<b>22d. LOCATION (City, town, or county)</b> (State) <b>CHESAPEAKE CITY, Md.</b>					
<b>23. REGISTRAR'S SIGNATURE</b> <b>PIPPIN FUNERAL HOME</b> <b>ADDRESS</b> <b>ELKTON, Md.</b>												<b>24a. REC'D BY REGISTRAR</b> <b>AUG 8, '61</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>Wm. J. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9035

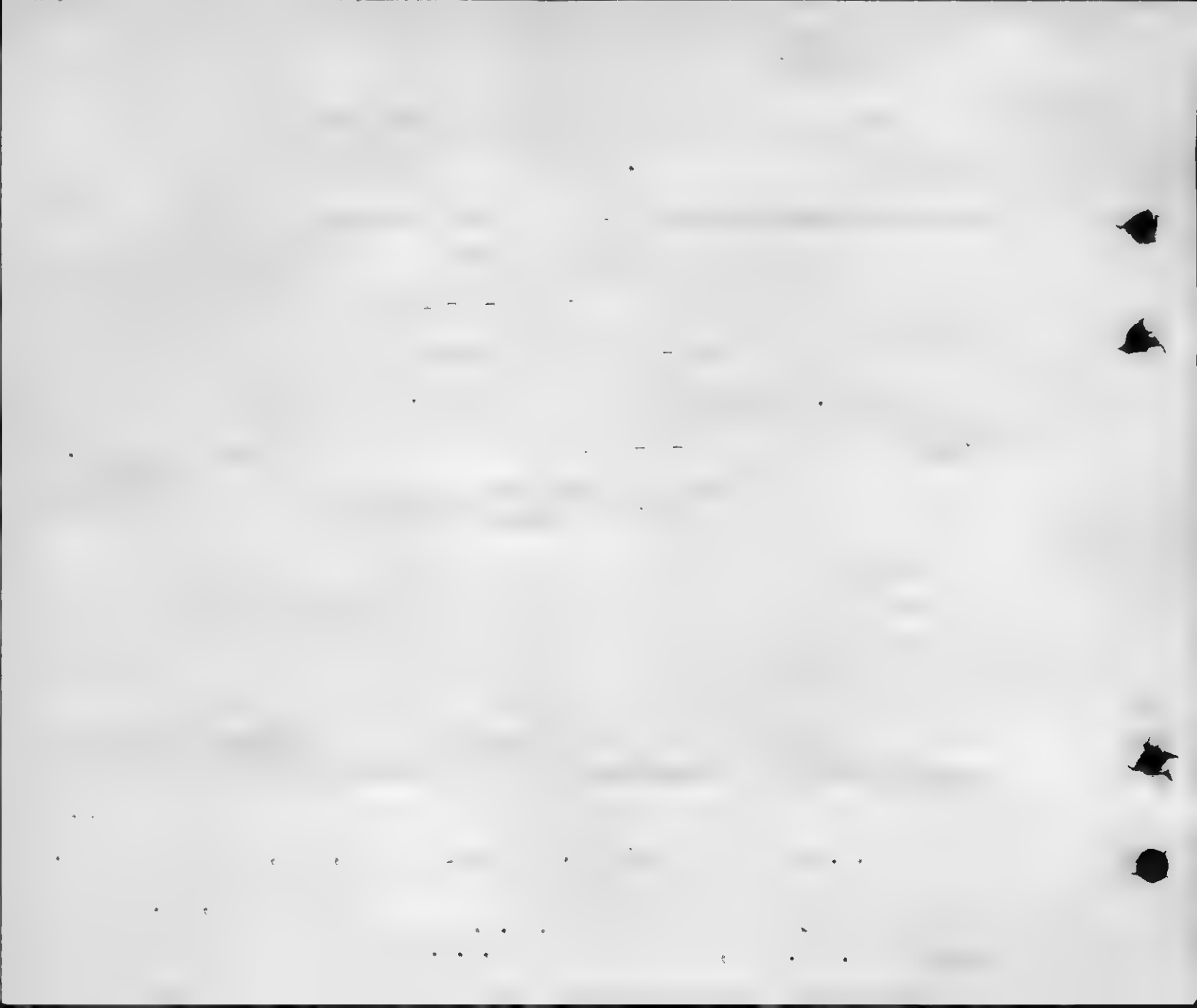
## CERTIFICATE OF DEATH

19027

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Cecil</u> <span style="float: right;">b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Perry Point</u></span> c. LENGTH OF STAY in 1b <u>1 mo 2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Veterans Administration Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>...</u></span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> d. STREET ADDRESS <u>4104 Gallatin</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>ALLEN</u> Middle <u>LAVERNE</u> Last <u>SUIT</u>		<b>4. DATE OF DEATH</b> Month <u>August</u> Day <u>1</u> Year <u>19 61</u>		<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input checked="" type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>11-20-01</u>		<b>9. AGE</b> (In years last birthday) <u>59</u> yrs. <table border="1" style="display: inline-table; vertical-align: top;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.																			
Months	Days	Hours	Min.																		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Paper Hanger</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Self-employed</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>									
<b>13. FATHER'S NAME</b> <u>Everett M. Suit (deceased)</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Hannah E. Allen (deceased)</u>															
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Yes</u> <u>WW-II</u>				<b>16. SOCIAL SECURITY NO</b> <u>579-07-6021</u>				<b>17. INFORMANT</b> Address <u>Hospital Records, VAH, Perry Point, Md.</u>													
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic anaplastic carcinoma (primary site undetermined)</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____												<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>unknown</u>									
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____												<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>VA</u> 19 <u>19</u> p.m. _____				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____		<b>20f. (City or town)</b> _____ (County) _____ (State) _____													
<b>21. I certify that</b> <u>B.S. Linn</u> attended the deceased from <u>June 30, 1961, to August 1, 1961</u> and that death occurred at <u>7:00 A.M.</u> from the causes and on the date stated above.																					
<b>22a. SIGNATURE</b> <u>B.S. Linn</u> M.D.												<b>22b. DATE SIGNED</b> <u>8-2-61</u>									
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>B.S. LINN Chief Resident, Surgical Service, VAH, Perry Point, Md.</u>												<b>22d. ADDRESS</b> _____									
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>Aug 4-61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Epiphany</u>				<b>23d. LOCATION</b> (City, town or county) <u>Forrestville, Md.</u> (State) _____											
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Simmons Bros.</u>						<b>ADDRESS</b> <u>Wash. D.C.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>AUG 4 '61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>William S. Thane</u>											
<b>15M 9/60</b>																					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 15M 9/60



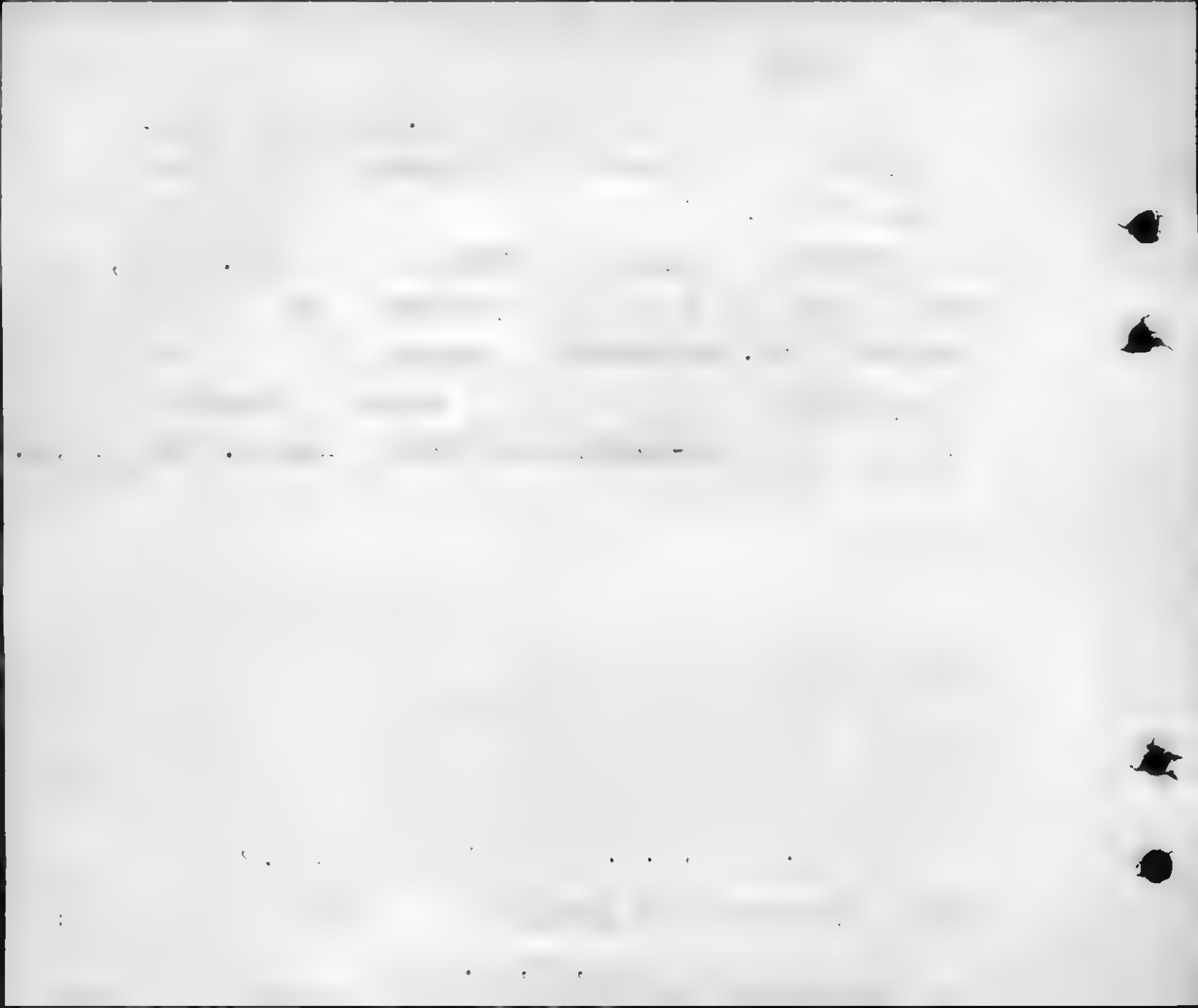
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

9036

09028

1 PLACE OF DEATH a. COUNTY <b>CECIL</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>CECIL</b>			
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>ELKTON</b>				c. LENGTH OF STAY IN 1b <b>9 weeks</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>UNION HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last <b>HORACE WILLARD TAYLOR</b>				4. DATE OF DEATH Month Day Year <b>AUG. 23, 1961</b>			
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>2/6/1886</b>	9. AGE (In years last birthday) <b>75</b> yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER RET. SELF EMPLOYED</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>JOHN TAYLOR</b>			14. MOTHER'S MAIDEN NAME <b>FRANCES FLAHERTY</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)			16 SOCIAL SECURITY NO <b>219-01-6605</b>		17. INFORMANT <b>RALPH TAYLOR</b> Address <b>14th ST. OCEAN CITY, MD.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Sigmoid Colon &amp; Metastasis</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <b>June 16, 1961</b> to <b>Aug 23, 1961</b> , that (I) (we) last saw the deceased alive on <b>Aug 22, 1961</b> , and that death occurred on <b>Aug 23, 1961</b> AM, from the causes and on the date stated above							
22a SIGNATURE <b>Frank D. Hauber</b>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b DATE SIGNED <b>Aug 24, 1961</b>		
22c PHYSICIAN'S NAME (Type) <b>Frank D. Hauber, M. D.</b>			22d ADDRESS <b>611 South Union Ave., Havre de Grace, Md.</b>				
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b DATE THEREOF <b>8/26/1961</b>		23c NAME OF CEMETERY OR CREMATORY <b>WEST NOTTINGHAM</b>		23d LOCATION (City, town, or county) (State) <b>COLORA MD.</b>	
24 FUNERAL DIRECTOR'S SIGNATURE <b>Wm. G. McMillen</b>				25a REC'D BY REGISTRAR <b>RISING, SUN., MD.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur J. Howard</b>	



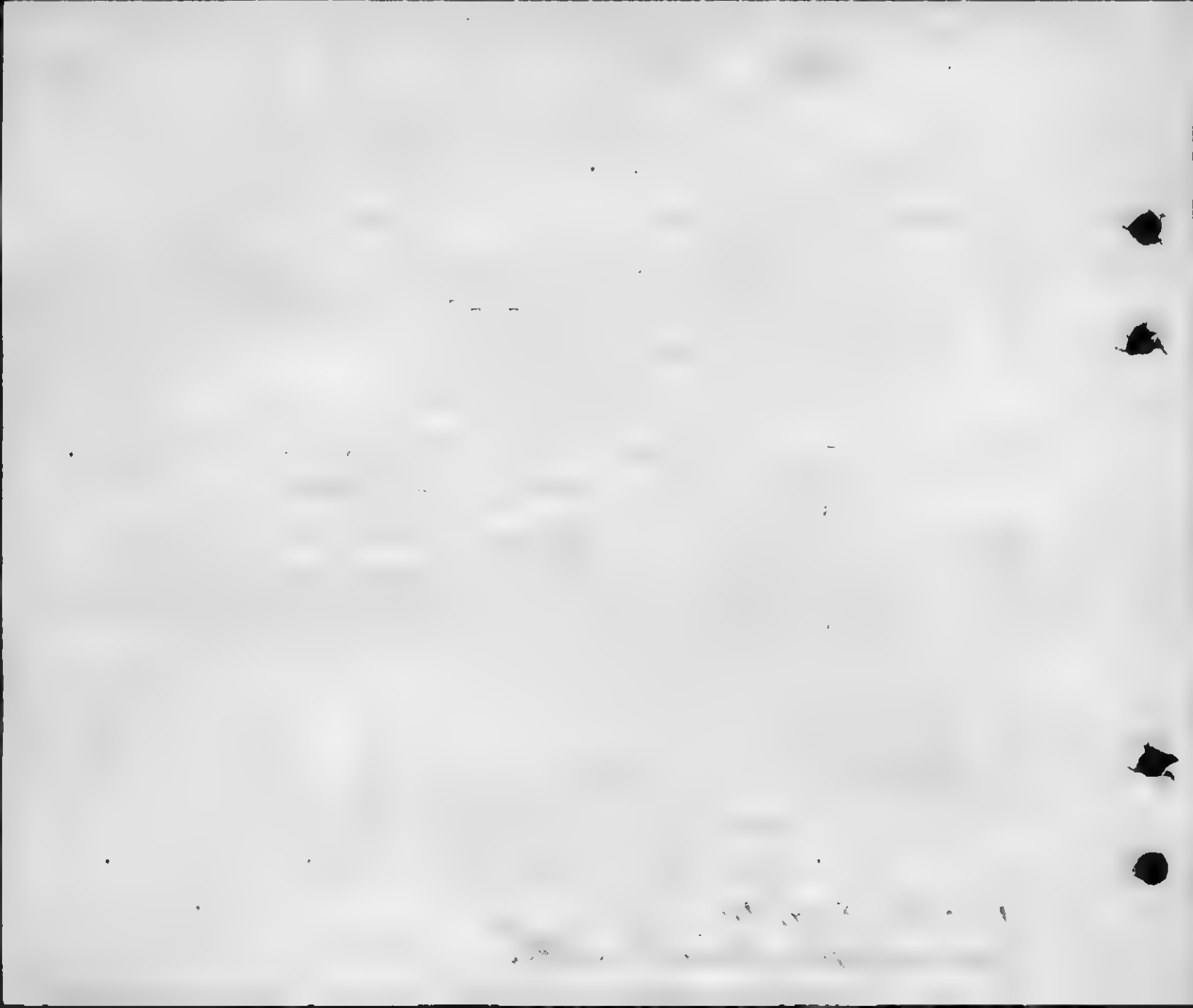
## 02029

Arthur L. Knecht

VR A15 (4)  
15M 9/60









1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

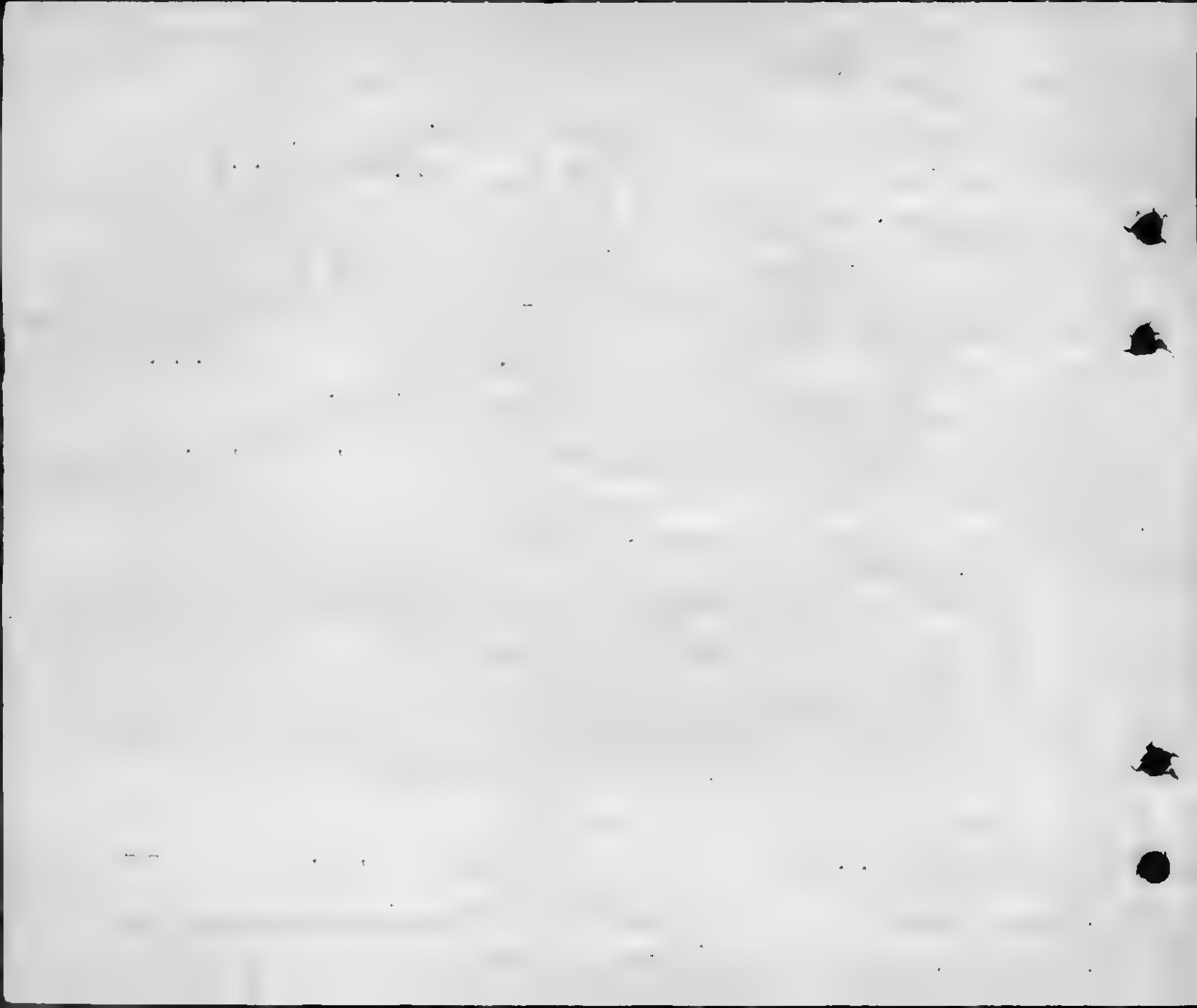
# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 9039 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09031

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Pa. b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East Rural		c. LENGTH OF STAY in lb few days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ashland R.D.1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Nazerine Camp Grounds				d. STREET ADDRESS 754			
3. NAME OF DECEASED (Type or print) Mabel		First Middle Last Tietsworth		4. DATE OF DEATH 8 6 19 61		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-12-1900	9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael Kessler		14. MOTHER'S MAIDEN NAME Laura Slotterback		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			
16. SOCIAL SECURITY NO. 200-22-8895		17. INFORMANT Wilbur Tietsworth, Ashland, Pa.		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420. Acute Coronary Occlusion Conditions, if any, which gave rise to immediate cause (b) Arteriosclerosis (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):				INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
ACTUAL SIGNATURE R.C. Dodson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 8-6-61	
EXAMINER'S NAME (Type) R.C. Dodson		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Rising Sun, Md.		Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-10-1961		22c. NAME OF CEMETERY OR CREMATORY Mabel U. B		22d. LOCATION (City, town, or country) (State) Mabel Schuykill Co. Pa	
23. FUNERAL DIRECTOR Joseph R Frank North East, Md				24a. REC'D BY REGISTRAR DATE AUG 9 '61		24b. REGISTRAR'S SIGNATURE C. L. Thomas	



1  
FOR STATE  
HEALTH DEPT.

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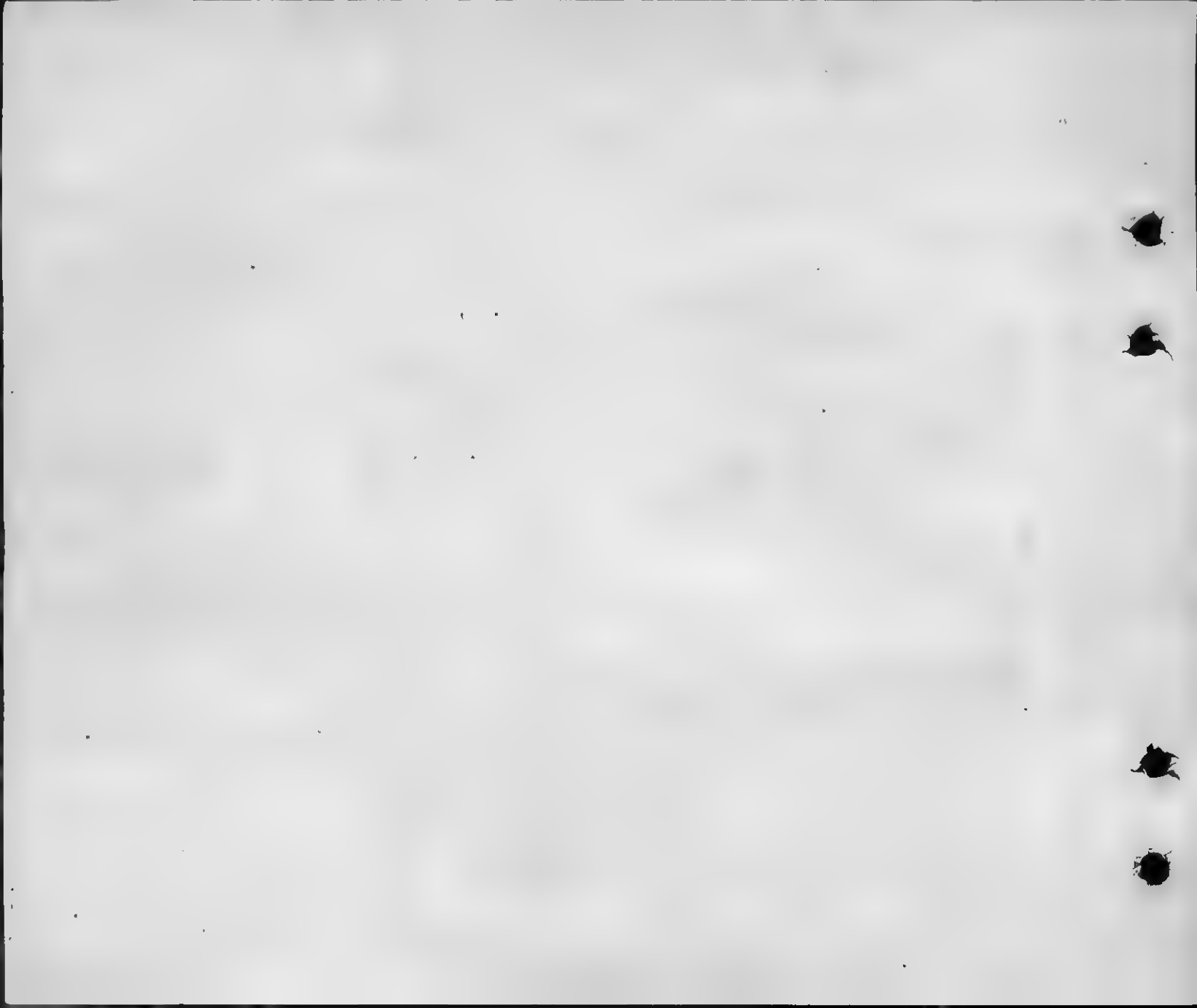
I

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

1  
MAYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
9040 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09032

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) North East Rural	
c. LENGTH OF STAY in 1b 8 days		d. STREET ADDRESS Shadow Trailer Park	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> X	
3. NAME OF DECEASED (Type or print) First Middle Last Randall D Ward		4. DATE OF DEATH Month Day Year Aug. 24 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 30, 1957
9. AGE (In years last birthday) 3 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	11. BIRTHPLACE (State or foreign country) Grundy, Virginia	12. CITIZEN OF WHAT COUNTRY USA
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY --	
13. FATHER'S NAME Lonzo T. Ward		14. MOTHER'S MAIDEN NAME Roaslie Fleming	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Address Lonzo T. Ward, Shadow Trailer Park, North East	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis from ruptured intestine (b) Fracture of Pelvis (c) DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell off Milk Truck - (was moving)	
20c. TIME OF INJURY Month, Day, Year 10 AM 8-16-61		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Shadow Trailer Park North East Cecil Md. (Rural)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		DATE SIGNED	
EXAMINER'S NAME (Type) [Signature]		8-25-61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-27-61	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) Grundy Va.	
23. FUNERAL DIRECTOR'S NAME (Type) Joseph R. Grant		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	
ADDRESS North East, Maryland		DATE AUG 28 '61	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)  
15M 9/55

Item 18 Film 293  
8-16-61 ams

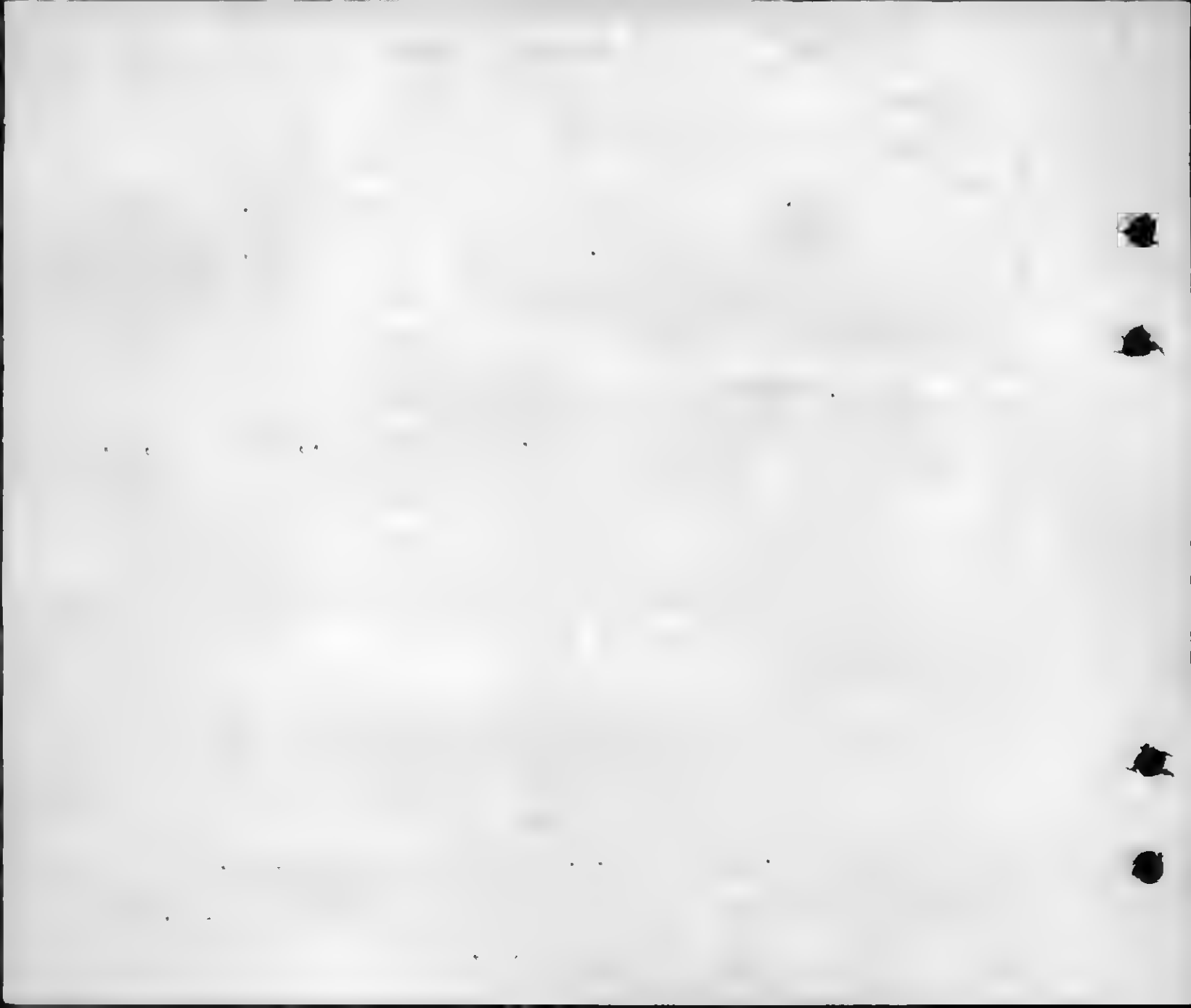
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9041

CERTIFICATE OF DEATH

Reg. Dist. No. 09033

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perryville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perryville</b>	
c. LENGTH OF STAY IN 16 <b>Life</b>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Broad St.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Broad St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Grace</b> Middle <b>S.</b> Last <b>Warner</b>		4. DATE OF DEATH Month <b>Aug.</b> Day <b>8</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 17, 1889</b>
9. AGE (In years last birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR Months <b>72</b> Days <b>72</b> Hours <b>72</b> Min <b>72</b>	11. IF UNDER 24 HRS. Months <b>72</b> Days <b>72</b> Hours <b>72</b> Min <b>72</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>John W. Cochran</b>		14. MOTHER'S MAIDEN NAME <b>Araminta Fray</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Donald Cole Sr., Perryville, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coro-vascular Embolus</b> 9. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Post-operative rining of fractured hip</b> DUE TO (c) <b>hip</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b> <b>5 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Pt. fell down coming out of church</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>7-2-61</b> 19 p. m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street - Church</b>		20f. (City or town) (County) (State) <b>Perryville Cecil Md.</b>	
21. I certify that I attended the deceased from <b>7-1</b> 19 <b>61</b> , to <b>8-8</b> 19 <b>61</b> , that I last saw the deceased alive on <b>8-3</b> 19 <b>61</b> , and that death occurred at <b>6:35 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Gunther D. Hirsch</b> M.D.		ADDRESS (Street, city or town, state) <b>8-9-1961</b>	
PHYSICIAN'S NAME (Type) <b>Gunther D. Hirsch M.D.</b>		DATE SIGNED <b>8-9-1961</b>	
22a. BURIAL, CREMATION, or DISPOSAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-10-1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Asbury Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Port Deposit, Md. Rural</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee A. Patterson &amp; Son,</b>		ADDRESS <b>Perryville, Md.</b>	
24a. REC'D BY REGISTRAR <b>AUG 11 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur P. Hume</b>	



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If at all delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours of death.

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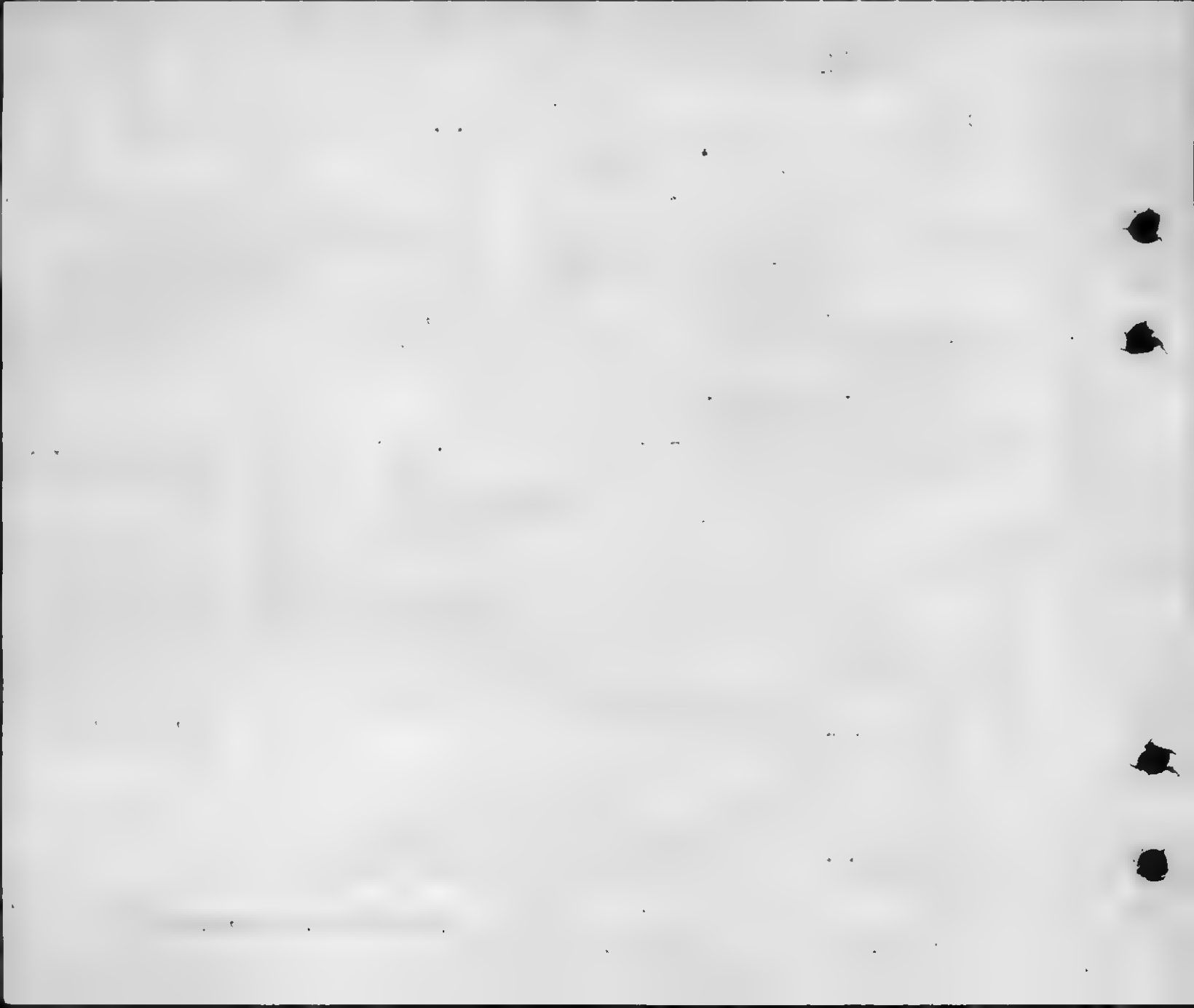
# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 9042 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18134

1. PLACE OF DEATH a. COUNTY <b>Cecil</b>				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <b>N.J.</b>				b. COUNTY <b>Gloucester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural North East</b>				c. LENGTH OF STAY in 1b <b>1 day</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glassboro</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Blk Neck State Park</b>				d. STREET ADDRESS <b>410 Franklin Rd</b>				b. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Dorothy Nichols Weir</b>				4. DATE OF DEATH <b>August 6 1961</b>				9. AGE (In years last birthday) <b>18 yrs.</b>			
5. SEX <b>Female</b>				6. COLOR OR RACE <b>white</b>				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>				11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>			
13. FATHER'S NAME <b>Gilbert S. Nichols Sr.</b>				14. MOTHER'S MAIDEN NAME <b>Elvena Van Note</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>149-34-7902</b>				17. INFORMANT <b>John W. Weir 410 Franklin Rd Glassboro N.J.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carbon-monoxide poisoning</b> DUE TO <b>charcoal stove burning in small closed tent</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <b>8-6-1961</b> Hour a.m. <b>?</b> p.m. <b>?</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>State Park</b> 20f. (City or town) (County) (State) <b>Rural North East, Cecil, Md</b>											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Rising Sun, Md</b>											
ACTUAL SIGNATURE <b>R.C. Dodson</b> EXAMINER'S NAME (Type) 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 22b. DATE THEREOF <b>8-12-1961</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Hill Crest Burial Park</b> 22d. LOCATION (City, town, or county) (State) <b>East Pitman Gloucester N.J.</b>											
23. FUNERAL DIRECTOR <b>Joseph R. Grant</b> ADDRESS <b>North East, Maryland</b> 24a. REC'D BY REGISTRAR <b>Arthur S. Frank</b> 24b. REGISTRAR'S SIGNATURE <b>DATE AUG 14 '61</b>											





Arthur L. Brand

THE STATE  
OF NEW YORK

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2003

RECEIVED BY THE STATE OF NEW YORK  
OFFICE OF THE ATTORNEY GENERAL  
JANUARY 1, 2003

TO THE HONORABLE THE ATTORNEY GENERAL  
STATE OF NEW YORK  
ALBANY

FROM THE HONORABLE THE ATTORNEY GENERAL  
STATE OF NEW YORK  
ALBANY

SUBJECT: [Illegible]

[The remainder of the document contains several paragraphs of text that are largely illegible due to extreme fading and blurring. The text appears to be a formal letter or memorandum.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

9044

09036

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b> c. LENGTH OF STAY IN 1b <b>37yrs. 11mo. 12days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Delaware</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Wilmington</b> d. STREET ADDRESS <b>1807 Green Lane, Arden</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ROBERT F. WHITESIDE</b>		4. DATE OF DEATH <b>August 22 19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-20-96</b>
9. AGE (In years last birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Leather Cutter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Wholesale Leather Establishment</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>Not available</b>		14. MOTHER'S MAIDEN NAME <b>Not available</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW-I</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Hospital Records, VAH, Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular arrhythmia</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Calcification of aortic valve</b> (c) <b>Arteriosclerotic heart disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10-15 min.</b> <b>unknown</b> <b>unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis generalized severe</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>VA 19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <del>XXXXXX</del> attended the deceased from <b>September 10 23</b> to <b>August 22, 19 61</b> and that death occurred <b>1:30 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>A. L. MOONEY</b>		22b. DATE SIGNED <b>8-23-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. L. MOONEY, Asst. Clinical Pathologist, VAH, Perry Point, Md.</b>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>buried</b>	23b. DATE THEREOF <b>8/24/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Gardens</b>	23d. LOCATION (City, town or county) (State) <b>Arden, Wilmington, Delaware</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Pennington &amp; Son</b>		25a. REG. BY <b>Pennington &amp; Son</b> REG. NO. <b>100</b> SIGNATURE <b>Clifford S. Thomas</b>	
25b. DATE <b>AUG 28 61</b>			

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